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DEVELOPMENTS IN AGING: 1986
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 353, SEC. 19, MARCH 13, 1986

Resolution Authorizing a Study of the Problems of the
Aged and Aging

FEBRUARY 27, 1987.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. Senate,
Special Committee on Aging,
Washington, DC, February 27, 1987.

Hon. George Bush,
President, U.S. Senate,
Washington, DC.

Dear Mr. President: Under authority of Senate Resolution 353, agreed to March 13, 1986, I am submitting to you the annual report to the Senate Special Committee on Aging, Developments in Aging: 1986, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1986 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

John Melcher, *Chairman.*

SENATE RESOLUTION 353, SECTION 19, 99TH CONGRESS, 2D SESSION[1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from February 28, 1986, through February 28, 1987, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,159,720, of which amount (1) not to exceed $35,000 may be expended for the procurement of the services of individual consultants or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

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[1] Agreed to March 13, 1986.

PREFACE

Two forces helped shape legislative activity affecting older Americans in the second session of the 99th Congress. The first of these was *Tax reform*. The massive effort to simplify the tax code and reduce the tax burden for individuals meant both an opportunity and a threat for the elderly. The tax reform bill which eventually emerged removed roughly 750,000 low income elderly from the tax roles and reduced taxes for many with modest incomes. It also ushered in profound changes in the treatment of private pension programs. The net result is that the elderly fared about as weil as other age groups in the short run, while in the long run, future generations of retirees—especially those in the so-called "baby boom"—will benefit greatly by improvements in access to and generosity of private pensions.

The second major force affecting legislation for older Americans was the *Gramm-Rudman-Hollings Act*. The deficit targets imposed by Gramm-Rudman-Hollings meant improvements in programs for the elderly were not possible unless they contributed to deficit reduction or were at least budget neutral. Consequently, no significant progress was made toward resolving the several major problems facing the elderly, most notably the crushing costs of long term care, persistent pockets of poverty and the decline in affordable housing.

Operating within these forces, the Special Committee on Aging contributed to an impressive record of legislative accomplishments during the final session of the 99th Congress. In health care, for example, Congress responded to this committee's 2-year investigation of deficiencies in quality of health care by enacting a long list of quality reforms in the Medicare Program. Among these are: An expansion of the scope of the watchdog Peer Review Organizations (PRO's); improvements in the rights of hospital patients; prohibitions against hospitals offering incentive payments to physicians for reducing care to Medicare patients; expansion of Medicare patient appeals rights; and, a study of ways to ensure access to appropriate post-hospital services.

Progress in health care quality was accompanied by legislation to increase access to care for the elderly poor and the unemployed. For example, the Medicaid Program was amended so that States now can offer coverage to all elderly (and pregnant women and children) who are at or below the poverty line, compared to previous law which set the eligibility limit at roughly 75 percent of poverty. Widows and the unemployed also were helped by legislation requiring employers to offer continued access to health insurance coverage at the group rate for a period of up to 3 years. Finally, the Medicare deductible, scheduled to rise at a rate more than twice that of hospital costs, was modified to slow its growth, thereby protecting the elderly sick from an enormous increase in out-of-pocket costs.

The critical health needs of the aged was only one of the major issues the committee addressed. Income and employment problems ranked equally high on the agenda. Here, too, Congress made significant strides forward, the most significant being the private pension reforms included in the Tax Reform Act of 1986. These reforms, drawn from a legislative package prepared by the Aging Committee, guarantee 2 million more "baby boom" retirees a pension and raise the average annual benefit levels by more than $1,800 in 1986 dollars.

Committee inititative and leadership also played a critical role in the fight to eliminate the last vestiges of age discrimination from the workplace. After years of focusing public and congressional awareness on the injustice of age-based mandatory retirement, the House and Senate Aging Committees successfully enacted legislation to remove the upper age limit in the Age Discrimination in Employment Act, thereby extending prohibitions against job discrimination to workers above the age of 70. At the same time, Congress enacted legislation to bar discrimination in the accrual of pension benefits to workers over age 65. The combined impact of these legislative changes is significant: thousands of older workers gained the freedom to earn a living unfettered by arbitrary and capricious age-based policies.

In its ongoing effort to improve the economic status of America's aged, the committee successfully urged passage of legislation to eliminate a technical flaw in Social Security which prevented payment of a cost-of-living adjustment (COLA) when inflation drops below 3 percent. With enactment of this bill, 30 million beneficiaries received a COLA in 1986, although inflation fell below 3 percent.

Where do we stand now on issues of importance to our Nation's seniors? Having improved quality and access in health care, private pensions and employment, what problems remain on the congressional agenda? Unfortunately, despite the significant gains in the 99th Congress, much remains to be done.

Eliminating proverty persists as one of the thorniest policy issues facing the Nation. Among the elderly, this problem is especially difficult. The overall poverty rate among the elderly declined markedly during the past two decades, largely because of improvements in Social Security benefits. Nonetheless, proverty among the aged is more widespread and long term than among any other adult age group. In 1985, the poverty rate for the elderly as a group was 12.6 percent, but subgroups of the elderly are even worse off. For example, 31.5 percent of the black elderly live in poverty; among Hispanics, 23.9 percent. For black women living alone, 54.5 percent—an unacceptable majority—fall below the official poverty line.

Poverty numbers, like statistics in general, often mask the human suffering they represent. To understand what it means to be old and poor, imagine living on less than $99 per week (the official poverty line in 1985) for food, housing, medical care, clothing, and any other costs which might arise. For the elderly, falling below poverty often is a one-way street with no way out. The old are more than twice as likely as the remainder of the population to be stuck in long-term poverty, which means being poor for 8 out of 10 years. Health care costs consume more than three times as much of their disposable income as the nonelderly. Faced with virtually no opportunities to increase their income, the specter of poverty and illness among the aged is frightening indeed.

The staggering problem of access to health care, for the aged and nonaged alike, has been thrust onto the legislative agenda during the past year. Thirty-seven million Americans lack health insurance. One-third of the U.S. population with family incomes below the poverty level are uninsured. These statistics highlight gaps in protection by the Medicaid Program for even the most needy Americans. Likewise, though nearly 98 percent of older Americans are enrolled in Medicare, more than one-quarter of their health care costs must be paid out-of-pocket.

President Reagan, in his 1986 State of the Union Address, and again in 1987, raised the issue of catastrophic health care costs. Since then, Secretary of Health and Human Services, Dr. Otis Bowen, coordinated a package of proposals to address catastrophic health care. Congress appears poised to act on some legislation to address this problem in the 100th Congress, though the major thrust is limited to expanding acute care coverage for the over-65 Medicare population.

Protecting the 300,000 older Americans who each year suffer an acute catastrophic illness that exceeds Medicare coverage is an important endeavor. There are, however, more than 2 million older Americans facing catastrophic *long-term care* expenditures who will not be helped by the current legislative effort. Solving their problems requires a major commitment on the part of the Federal Government, as well as renewed efforts by the private sector. Private long-term care insurance has grown in popularity. But recent analyses by the Brookings Institution indicate that even under generous assumptions, private insurance will cover no more than 20 percent of the Nation's long-term care bill by the year 2020. The remainder must come from the public sector, either through an expansion of Medicare, a redesign of Medicaid, or a new Federal program.

Another threat to the health security of older Americans comes from the more recent trend by some employers, especially those in bankruptcy, to curtail or reduce health protections for their retirees. Presently, 7 million retirees receive health benefits from their former employer. Several recent and highly publicized bankruptcies—such as the LTV Corp. in which 78,000 retirees temporarily lost their health benefits—dramatize the need for improved protections for retirees. The committee has been instrumental in developing information on post-retirement medical benefits and has conducted hearings and prepared legislation to prevent unilateral termination of these benefits in bankruptcy.

The above record demonstrates a particularly productive year for the committee measured in legislative accomplishments. The committee's work, however, extends beyond making legislative recommendations. In the past year we have continued to investigate a wide range of problems affecting the elderly, informing the public through committee prints, newsletters, and public hearings. For example, a 10-month committee investigation highlighted the hazards in reuse of disposable kidney dialysis devices. The subsequent report and hearing served to educate health care providers, while warning the public about a potential health risk. Similarly, an investigation into quality of care in nursing homes led to widespread press attention and public awareness of a number of chronically substandard nursing homes throughout the Nation.

The Gramm-Rudman-Hollings (GRH) legislation made significant changes in the budget process, all of which were implemented for the first time in 1986. The committee analyzed the first GRH sequestration during the early months on the year and issued an information print for use by the Congress and the public to assess the impact of this new law on programs serving older Americans. A second print was issued later in the year analyzing the President's budget proposals for fiscal year 1987 and alternative budget proposals, including the impact of a second GRH sequestration.

The committee continues its long tradition of issuing informative material designed to improve the policymaking process and to educate the public about the most pressing issues facing the Congress. The committee reported on the health status and health care needs of older Americans and the costs of mandating pension accruals for older workers. The committee produced demographic studies of America in transition to an older society and issued a thought provoking piece on planning ahead for health care decisions in the face of dependency. Each of these has helped to destroy myths and illustrate unmet needs.

The report that follows discusses developments of importance to older Americans in 1986. In line with changes implemented in 1984, the report surveys only Federal policies and programs and focuses exclusively on the major policy issues facing Congress and the legislative activity on these issues that transpired in 1986. Demographic data is still issued in Volume III, as it was for the first time last year. These and other changes are intended to make this report more informative and easier to use.

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This report is a synthesis of the extensive working knowledge they bring to the committee.

The graying of America presents us with significant challenges and opportunities. Providing for the health, income, and housing needs of this ever-growing older population are only a few of the challenges. We must also seek better ways to enable older Americans to remain productive and independent. Our greatest challenge then is to expand opportunities, to put to use the full talents of this vast resource so that the promise of long life is worth living.

JOHN MELCHER,
Chairman.
JOHN HEINZ,
Ranking Member.

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REPORT 100-9
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DEVELOPMENTS IN AGING: 1986 VOLUME 1

FEBRUARY 27, 1987.—Ordered to be printed

Mr. MELCHER, from the Special Committee on Aging, submitted the following

REPORT

Chapter 1

SOCIAL SECURITY—RETIREMENT AND DISABILITY

OVERVIEW

In 1986, attention on Social Security diminished with the resolution of the long term financing problems that dominated the 1980-83 period. Long term concerns continued to focus on Social Security's relation to other Government programs and to the unified budget process, despite 1985 legislation that removed Social Security from the budget. Congress also continued its concern with a variety of issues that have surfaced regarding the Social Security Administration's [SSA] administration of its programs.

The most noteworthy actions in 1986 were the elimination of the 3-percent inflation COLA trigger, and SSA's absorbtion of a 4.3 percent cut in its administrative budget as a result of automatic spending cuts under the Gramm-Rudman-Hollings Act.

With the decline of concerns over funding problems, increasing attention has been focused on criticism of the management of the Social Security Administration. Problems which received the most attention included the closing of SSA field offices, staff reductions, recovery of excess benefits payments, and mismanagement of computer contracts.

Activity regarding the Disability Insurance [DI] program continued its shift from the 1981-84 period, which culminated in the Social Security Disability Benefits Reform Act of 1984. That act is designed to thoroughly reform the disability determination system.

In response to the act, SSA spent 1985 developing new rules and procedures for implementing the changes, then spent 1986 training its operations in the application of the new system. Processing of cases did not begin until late 1986, making it difficult to evaluate the new rules and their effect on beneficiaries until 1987. Several issues may arise in the DI program during 1987, including: What role the courts will play in the review of previously denied cases; how SSA will handle the backlog of cases that has built up; and the percentage of cases that will be terminated under the new rules.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Background

Old age and survivors insurance [OASI] and disability insurance [DI] benefits are the basic benefits provided under title II of the Social Security Act. They are based on a worker's earnings in Social Security covered employment and are designed to replace a portion of the income that individuals and families lose when workers retire, die, or become disabled. At the end of September 1986, 37.5 million beneficiaries under the OASDI Program were receiving $16.2 billion in monthly cash benefits. Retired workers numbered 22.8 million and accounted for 61 percent of all OASDI beneficiaries. Disabled workers numbered 2.7 million and accounted for 7 percent of the total. Average monthly benefit amounts payable in September were $482 both for retired and for disabled workers.

The functions of the Social Security Administration touch the lives of nearly every American. During 1985, about 122 million workers made contributions to the OASDI program. At the end of September 1985, 36.9 million persons were receiving monthly OASDI benefits payments. Administration expenses represented about 1.2 percent of benefit payments in fiscal year 1985. More than 270 million Social Security numbers have been issued and an estimated 235 million persons have sufficient earnings credits to qualify for retirement and survivors protection.

(A) HISTORY AND PURPOSE

Enacted in 1935, the Social Security Program was designed to begin as a modest program with a relatively low tax rate and grow in stages until it reached maturity in the 1980's. As its architects anticipated, Social Security has only recently come of age, with the first generation of lifelong contributors retiring and beginning to draw benefits. While Social Security has expanded and changed substantially over the course of its development, the basic principles which guided the framers of the old-age pension program in 1935 have remained unaltered.

The design of Social Security reflects a compromise among a variety of purposes. This compromise is both a key to the program's broad-based political support and a cause of much of the criticism it receives. For while Social Security provides a mixture of insurance protection, earned pension benefits, and minimally adequate income in old age, it must make separate concessions in the value of each to achieve a combination that works. One current method of criticizing the program has been to evaluate the quality of benefits from only one perspective. For instance, many point to the possibility that rates of return on Social Security taxes paid by the highest wage earners may, in the long run, compare poorly with the rates of return on private investments. While it may be popular when discussing Social Security with a younger worker to focus on only one aspect of the system, this results in a distorted evaluation of the larger purposes of Social Security.

To ensure an accurate picture of the program, there are a number of features that should be factored into any equation which attempts to measure the value of Social Security.

First, Social Security provides younger workers with protection from the unpredictable and random costs of financial support for their own aged parents and relatives. The pay-as-you-go financing for Social Security, seen from this perspective, uses periodic payments by younger workers to insure their own earnings against the cost of parental support. By spreading these costs across the working population, younger workers have a smaller, fairer, and more predictable financial burden, and their parents have a degree of financial independence. This aspect of the program justifies universals coverage, since exemptions from coverage permit individuals to pass to others the costs of supporting their own parents. It also justifies features which will provide adequate retirement and survivors benefits so that younger workers will be fully protected from having to supplement the incomes of their relatives.

Second, Social Security provides workers and their families with a "floor of protection" against suddent loss of their earning due to their own death, disability, or retirement. This insurance is intended to protect only a portion of the income needed to preserve the previous living standard of the worker and his family, and is to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker. Receipt of benefits is based on the occurrence of an insured-against event, such as retirement, which is determined by comparing the individual to some "test" or standard, such as the retirement or earnings test. Should the individual meet the test, benefits are then provided regardless of any income from other sources.

Third, Social Security provides the individual wage earner with a basic pension benefit upon retirement. Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating service credits. This mixture of features in Social Security has been the source of public confusion about the program over the years. The similarities between Social Security and a pension, for example, have led many people to believe that the system is funded, as a private pension might be, through workers' contributions invested in a trust fund account and used to pay benefits in the future. Others focus on the rate of return on contributions—as if Social Security were a form of individual investment.

A program with the essential social functions and multiple purposes of Social Security defies comparison with other financial or insurance vehicles. While a particular vehicle, such as an individual retirement account [IRA], may perform one function more successfully for some than does Social Security, no single vehicle could perform the unique combination of functions without approximating Social Security in its features. Most criticisms of Social Security, therefore, readily translate into criticisms of its mix of functions. For example, some critics believe Social Security ought to be only a pension plan, leaving the insurance and intergenerational support functions to specially tailored alternative programs. Others argue that Social Security should be a welfare program, providing basic benefits to the poor, and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRA's. Though the use of separate programs would eliminate the compromises entailed in Social Security, it could also raise tremendously the total cost of performing all of Social Security's functions, and most likely jeopardize the widespread political support that has developed for the program.

The Social Security Program, which was created during the Great Depression, is only now becoming a mature social insurance program. The decade of the 1980's marks the first generation of lifelong contributors retiring and beginning to draw benefits. Also during this decade, it is expected that payroll tax rates, eligibility requirements, and the relative value of monthly benefits will finally stabilize at the levels planned for the system.

(B) FINANCING

(1) Financing in the 1970's

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to meet any disruptions in expenditures or income due to unforeseen economic fluctuations. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: Relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecasted. High levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across the board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "overindexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

Recognizing that the financial status of the Social Security trust funds was rapidly deteriorating, Congress responded by enacting the Social Security Amendments of 1977. The 1977 legislation increased payroll taxes beginning in 1979, reallocated a portion of the Medicare [HI] payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI Program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as forecasts had predicted. The long-term deficit, which had not been fully reduced, remained. After 1979, annual increases in the CPI exceeded 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI Program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

The 96th Congress responded to this crisis by temporarily reallocating a portion of the DI tax rate to OASDI for 1980 and 1981. This measure was intended to postpone an immediate financing crisis in order to allow time for the 97th Congress to comprehensively address the impending insolvency of the OASDI trust funds. In 1981, a number of proposals were introduced to restore short- and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial, and enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay imposed by the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. But the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(2) The Social Security Amendments of 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package improved financing by $166 billion between 1983 and 1989, and eliminated a deficit which had been expected to average 2.1 percent of payroll over 75 years.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions for new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions included:

Coverage.—All Federal employees hired after January 1, 1984, were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

Benefits.—COLA increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA fail-safe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation.—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue to be funneled back into the retirement trust fund.

Payroll taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement age increase.—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the year 2000 to 2022.

The 1983 amendments have caused a major improvement in the condition of the OASDI trust funds. Based on intermediate assumptions, it is expected that reserve ratios will increase from a low of 11 percent of annual outgo at the beginning of 1983 to 47 percent of outgo by the beginning of 1989. These reserves should be sufficient to continue uninterrupted benefit payments throughout the decade, and repay the HI trust fund for previous loans.

(3) OASDI Near-Term Financing

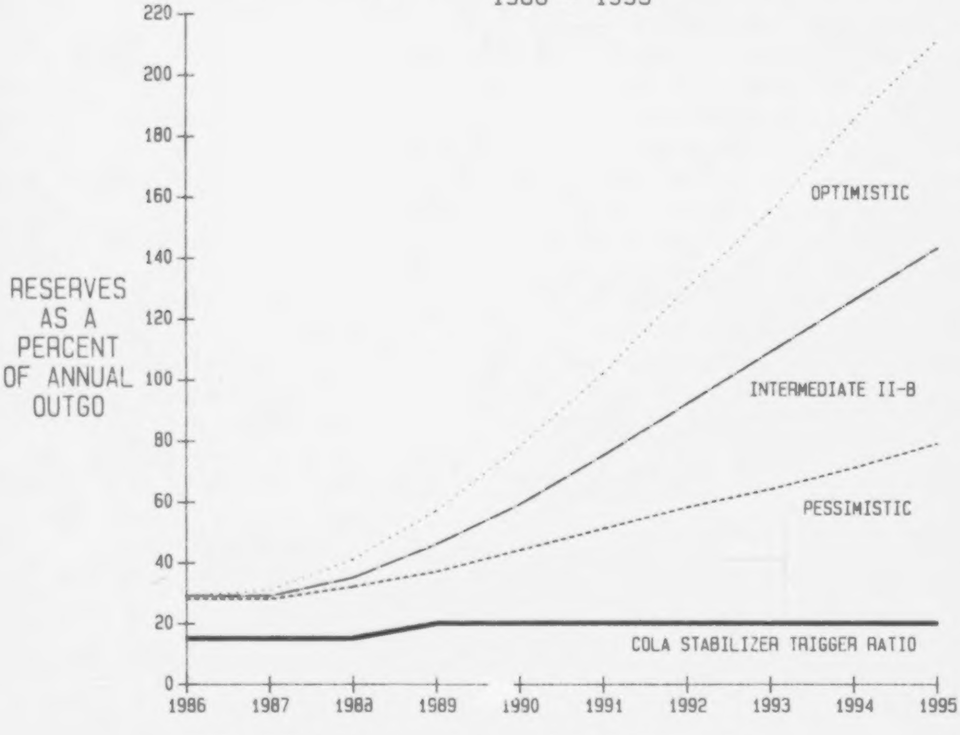
In the short term, OASDI funds are anticipated to increase steadily each year under all but the most pessimistic assumptions employed by Social Security actuaries. Under pessimistic assumptions, reserve ratios are expected to decline slightly, and then increase again in 1988. The short-range estimates reported in the 1986

Social Security trustees report are more favorable than those that informed the 1983 legislative efforts, due to the strength of the economic recovery. It is likely that in the aggregate, the OASDI trust funds will continue to grow faster than anticipated in the 1983 legislation, even though the costs of the DI program can be expected to increase as a result of the 1984 DI reform legislation.

Overall, the OASDI reserves are expected to expand considerably in the near future. Only in the next 2 years, until the scheduled 1988 payroll tax increase goes into effect, are the reserves at all slim. Under all sets of assumptions in the 1986 Social Security trustees report, the OASDI contingency funds are expected to remain between 28 and 31 percent of projected outgo until 1988. Beginning in 1988, the OASDI reserves are expected to begin a steady buildup as a result of the scheduled 1988 and 1990 tax increases and an anticipated leveling off in the growth rate of new retirees. Under intermediate assumptions, the OASDI contingency funds are expected to grow from 35 percent of outgo in 1988 to 143 percent by 1995.

CHART 1-1

OASDI RESERVE RATIOS UNDER ALTERNATIVE ASSUMPTIONS
1986 - 1995



SOURCE: 1986 Report of the Trustees of the OASDI Trust Funds

TABLE 1-1.—COMBINED OASDI RESERVE RATIOS AS A PERCENTAGE OF ANNUAL OUTGO UNDER ALTERNATIVE ASSUMPTIONS: 1986-1995

Calendar year	Optimistic	Intermediate II-B	Pessimistic
1986	29	29	28
1987	31	29	28
1988	41	35	32
1989	57	46	37
1990	78	59	44
1991	102	75	51
1992	130	92	58
1993	155	109	64
1994	185	126	71
1995	211	143	79

Source: 1986 Trustees report, table 31, p. 75.

(4) OASDI Long-Term Financing

In the long run, the Social Security trust funds appear to be in close actuarial balance, meaning that over the next 75 years, it is projected that the taxes collected for Social Security will fall within plus or minus 5 percent of the amount needed to pay benefits. Under current projections based on intermediate assumptions, the trustees predict that the trust funds will remain solvent throughout the next 75 years.

Although the OASDI trust funds remain healthy, under forecasts for the long term it should be emphasized that trust fund experience in each of the three 25-year periods between 1986 and 2060 varies considerably. In the first 25-year period—1986 to 2010—the trust funds are expected to accumulate rapidly, and maintain an annual surplus of revenues equal to 2.12 percent of taxable payroll. As a result of these surpluses, OASDI reserves are expected to build to over 200 percent of annual outgo by the year 2000.

In the second 25-year period—2011 to 2035—the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow to over 500 percent of annual expenditures by 2015, and then decline, reaching 258 percent of outgo by 2035. The combination of surpluses and deficits will result in an average deficit of 0.89 percent of taxable payroll over this 25-year period.

The third 25-year period—2036 to 2060—is expected to be one of continuous deficits. Program costs will grow until 2035 and level off, remaining above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Annual deficits over the 25-year period are expected to average 2.56 percent of taxable payroll.

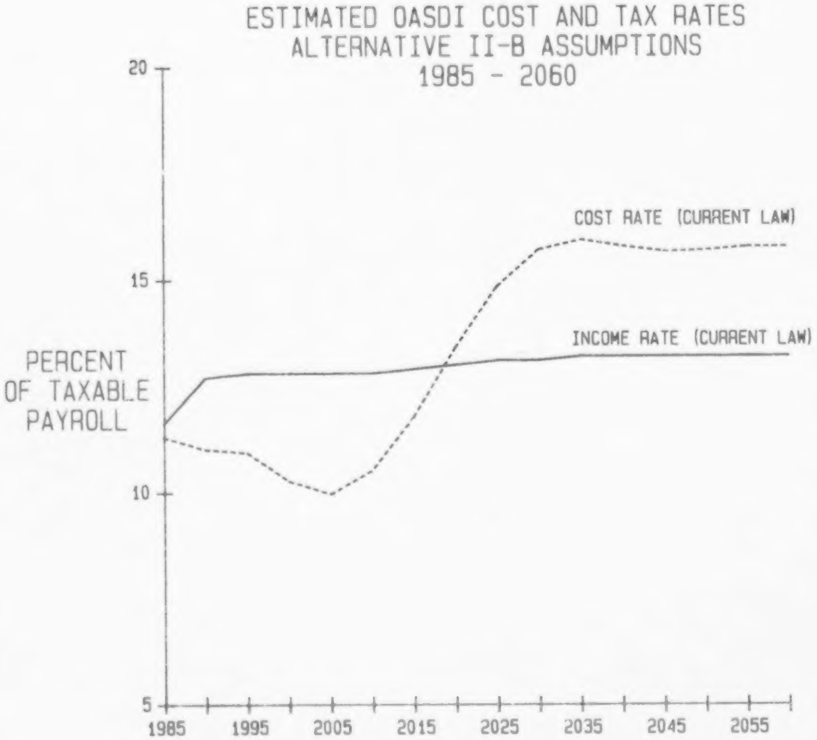
TABLE 1-2.—COMPARISON OF ESTIMATES COSTS RATES AND INCOME RATES OF THE OASDI PROGRAM, ON THE BASIS OF ALTERNATIVE II-B, CALENDAR YEARS 1986-2060

[As a percentage of taxable payroll]

Calendar year	Cost rate			Income rate			Balance
	OASI	DI	Total	Payroll tax	Taxation of benefits	Total	
Alternative II-B:							
1986	9.98	1.13	11.11	11.40	0.21	11.61	0.50
1987	9.93	1.09	11.02	11.40	.22	11.62	.60
1988	9.99	1.07	11.07	12.12	.24	12.36	1.30
1989	9.89	1.05	10.94	12.12	.26	12.38	1.45
1990	9.96	1.04	11.00	12.40	.34	12.74	1.74
1991	9.94	1.03	10.96	12.40	.31	12.71	1.75
1992	9.90	1.02	10.92	12.40	.33	12.73	1.82
1993	9.88	1.01	10.89	12.40	.36	12.76	1.87
1994	9.88	1.02	10.90	12.40	.39	12.79	1.89
1995	9.90	1.03	10.92	12.40	.43	12.83	1.91
2000	9.13	1.12	10.25	12.40	.41	12.81	2.55
2005	8.64	1.31	9.95	12.40	.39	12.79	2.84
2010	8.96	1.55	10.51	12.40	.43	12.83	2.32
2015	10.08	1.69	11.77	12.40	.50	12.90	1.13
2020	11.62	1.77	13.40	12.40	.58	12.98	−.41
2025	12.96	1.88	14.84	12.40	.67	13.07	−1.77
2030	13.85	1.84	15.70	12.40	.73	13.13	−2.57
2035	14.15	1.78	15.93	12.40	.76	13.16	−2.78
2040	14.00	1.77	15.77	12.40	.77	13.17	−2.60
2045	13.82	1.83	15.65	12.40	.79	13.19	−2.46
2050	13.83	1.86	15.69	12.40	.79	13.19	−2.50
2055	13.92	1.85	15.77	12.40	.79	13.19	−2.57
2060	13.95	1.82	15.77	12.40	.79	13.19	−2.58
25-year averages:							
1986-2010	9.37	1.17	10.54	12.30	.37	12.67	2.12
2011-2035	12.13	1.78	13.91	12.40	.62	13.02	−.89
2036-2060	13.92	1.82	15.74	12.40	.78	13.18	−2.56
75-year average:							
1986-2060	11.81	1.59	13.40	12.37	.59	12.96	−.44

Source: 1986 Trustees report, tables 28 and 29.

CHART 1-2



ESTIMATED OASDI COST AND TAX RATES
ALTERNATIVE II-B ASSUMPTIONS
1985 - 2060

SOURCE: 1986 Report of the Trustees of the OASDI Trust Funds

(a) Midterm surpluses

In the years between 1990 and 2025, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these surpluses will be invested in interest-bearing Federal securities, and will be redeemable to Social Security in the years in which benefit expenditures exceed payroll tax revenues—2025 through 2060. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used, indirectly, to finance other Government expenditures or reduce the public debt. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two methods have vastly different distributional consequences.

Social Security is fiananced by a regressive payroll tax, whose regressivity is justified on the basis that the benefit structure is progressive. The key policy issue is the significance of either scenario in the larger picture of the total Federal budget. In both instances, there is an incentive to spend surplus revenues in the 1990's and cut back on underfunded benefits after 2020.

What will happen to the surpluses Social Security lends to the general fund? These funds will enable Congress to spend money elsewhere without raising taxes or borrowing. This money could be used to fund new Federal programs, to reduce and possibly eliminate the budget deficit, or, with sufficient surpluses, to pay off the national debt. What will happen when this debt has to be repaid to Social Security? Either general revenues will have to be increased, or spending will have to be cut.

There are a number of alternative policy options for addressing the surplus/shortage problem. One choice would be simply to cut OASDI taxes in the coming decades, and encourage workers to save privately for their retirement—through tax favored IRA's for example—and reduce future Social Security benefits for those who do so. Alternatively, Congress could choose to create a floating tax rate, which would increase or decrease in direct relation to expenditures. This method would conform to the pay-as-you-go model of financing. Another option would be to direct a portion of the surplus OASDI revenues to the Medicare [HI] trust fund, which is expected to face severe financing problems in the coming years.

(b) Long-term deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The first part of this problem is that there are expected to be proportionately more older people, living longer, and continuing to retire early. Second, unusually high birth rates after World War II have already created a bulge in the population—the baby-boom generation—which is expected to reach retirement age beginning in 30 years. If life expectancy continues to rise and fertility rates stay low, as currently expected, the magnitude of this problem will be very great.

The relative increase in the number of beneficiaries per worker will not necessarily threaten the solvency of Social Security if productivity gains in the future compare to the experience of the past 30 years. Even though the ratio of workers to beneficiaries may decline, this can be offset by economic growth and increased real wages.

Another way of describing this is to point out that while the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily increase greatly over levels experienced in the 1970's. Currently, Social Security benefits cost 4.9 percent of the GNP. Under intermediate assumptions—

with 1.5 percent real wage growth—Social Security is expected to rise to 6.3 percent of the GNP by 2030, declining to 5.8 percent by 2060.

However, this relative increase in the number of beneficiaries will be a problem, despite productivitiy increases, if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base, and might undermine the long-term solvency of the system.

At this time, there are neither short-term nor long-term deficits projected in the OASDI trust funds, and though there are a wide variety of issues that must be considered in the future, there is no compelling need for Congress to make major changes in Social Security in the near-term. However, it should be emphasized that Social Security is vulnerable to general economic conditions, and should they deteriorate, Congress may need revisit the financing of the system. Furthermore, Social Security may be subject to external political pressures to change its structure, notwithstanding its financial condition. Congress may well ignore the internal solvency of Social Security in the coming years and cut benefits in order to lower Federal deficits.

2. Issues

(A) SOCIAL SECURITY'S RELATION TO THE BUDGET

Since 1981, the Congress has worked continuously through the annual process of deciding on a Federal budget to limit Government spending and reduce growing Federal deficits. In response, many advocates have proposed separating decisions about the operations of the Social Security Program from the Federal budget process. As a major part of total Federal income and outlays, Social Security has stood out as a prime target for budget cutting proposals. Social Security cuts were made as part of the 1981 budget reconciliation bill and subsequently proposals have been advanced to defer or freeze the annual cost-of-living adjustments [COLA's].

At the heart of this debate lie fundamental differences of perspective regarding the relation of Social Security to other Government programs. Advocates of removal from the budget process cite several reasons in support of their position: (1) Social Security has long-range goals—it aims to provide retirement income and disability insurance that all Americans can rely on for the future—that are incompatible with the short-term revenue and spending concerns of the yearly budget cycle; (2) Social Security is funded by a separate payroll tax that is deducted from the Social Security trust funds, so the effects of a shortage of revenue or an excess of spending in other areas of the budget should not be allowed to spill over into the Social Security program; (3) inclusion of Social Security in the budget allowed the politics involved in the budget debate to complicate and confuse policy questions regarding the future of Social Security; and (4) confidence in the system suffers by the impression that retirement plans must be constantly adjusted in response to the changing political climate.

Those who support inclusion of Social Security in the budget process make several points: First, that the Federal budget contains many programs that fulfill long-range goals, and that Social Security should not be excepted; second, that it is impossible to comprehensively confront the Government's taxing and spending problems without including Social Security, which will account for roughly 20 percent of Government outlays in fiscal 1987; third, that despite its long-range goals, Social Security should remain responsive to political processes, which rightly control all of government in a democracy.

Another aspect of the debate centers on the effect on the budget process of the expected surpluses in the Social Security trust funds. In 1987 the system is expected to take in approximately $15 billion more in taxes than it pays in benefits. By 1990, after two scheduled payroll tax increases, the yearly surplus will amount to an expected $55 billion. Many feel that the inclusion of this large surplus in the budget disguises the magnitude of the deficits created by the balance of the Government's taxing and spending policies, and might reduce the pressure on Congress to reduce those deficits.

The off-budget issue has been partially resolved by the 1983 Social Security Amendments and by the Gramm-Rudman-Hollings Act in 1985. The 1983 amendments required Social Security to be removed from the budget process by fiscal year 1993. Gramm-Rudman-Hollings accelerated the removal to fiscal year 1987, but that removal turned out to be less than total. Under the Gramm-Rudman-Hollings Act it is more difficult, but not impossible to consider transfers in Social Security benefits as part of a budget resolution or reconciliation bill. Social Security income and outlays are to be excluded from budget documents, budget resolutions, and reconciliation legislation.

However, under Gramm-Rudman-Hollings, Social Security's annual surpluses or deficits are taken into account in the calculation of the deficit targets. Were it not for the inclusion of the large Social Security surpluses, the budget deficit would have to be cut by an additional $50 to $60 billion in order to meet the targets set for the final years of Gramm-Rudman-Hollings.

(B) DISINVESTMENT OF THE TRUST FUNDS

Confidence in the Social Security system suffered a blow, and substantial confusion was generated as a result of actions taken by the Treasury Department during the debt ceiling crisis of late 1985. In September, Treasury began to run out of cash as it approached the debt ceiling, thus losing its ability to borrow from the general public to fund the Government's operating deficit. In order to generate cash for the purpose of making benefit payments, Treasury "disinvested" or cashed in long-term securities held by the old age and survivors insurance [OASI] and disability insurance [DI] trust funds. The public generally perceived that Treasury had used trust fund assets to operate other Government programs. Many also protested the loss of interest that the funds would have suffered when the disinvested amounts were reinvested in long-term securities in June of 1986. Interest loss would have resulted due to the lower interest in 1986. The impact of the problem was compounded by the revelation, in hearings before the Senate Finance Committee, that Treasury had previously disinvested Social Security funds in August of 1984, with a loss of interest and without notifying Congress of its actions.

The problem surfaced again in 1986, when Treasury reached the debt ceiling on September 30 and was unable to credit the trust funds with an advance payment of payroll tax revenues. The trust funds did not lose interest however, because, despite its lack of borrowing authority, Treasury had sufficient cash to pay benefits in early October without disinvesting. However, it was apparent that a serious loss of confidence could result if Congress did not take some action to prevent or at least regulate Treasury's disinvestment practices.

Disinvestment of the trust funds was made possible by virtue of the relationship between assets of the trust funds and the calculation of the debt ceiling. The debt ceiling as presently calculated includes not only debt issued by the Treasury to the private sector, which totalled $1,703 billion at the close of July 1986, but also Treasury debt issued to various Federal trust funds, which totalled $346 billion. The principal trust funds holding Treasury debt are the Social Security OASI, DI, and Hospital Insurance [HI] and the Black Lung, Highway, Airport, Military Retirement, Railroad Retirement, Civil Service Retirement, Revenue Sharing, Foreign Military Sales, and Toxic Waste Superfund trust funds.

Debt issued to trust funds is fundamentally different from debt issued to the private sector. Trust fund debt generally arises as a result of the method which Treasury uses to account for the receipt of tax revenues which are dedicated to a specific purpose. In the case of the Social Security Old Age and Survivors Insurance Trust Fund for instance, Treasury credits the fund at the beginning of each month with the estimated amount of payroll retirement taxes that it expects to receive during the course of the month. The credit to the fund takes the form of short-term special debt issues—a type of security which is in effect an internal Government I.O.U. from Treasury's operating cash account to the retirement fund. Although these securities do not represent debt issued to the general public, they are included in the calculation of total Government debt for purposes of the "debt ceiling"—the statutory limit on total Government borrowing. These securities are cashed in over the course of the month as the general revenue account pays out benefits. When payroll taxes exceed benefits, as they currently do, securities accumulate in the trust fund accounts. On June 30 of each year, the accumulated securities are converted to long-term special debt issues, which also count against the debt ceiling. The balance in the trust fund thus represents the total amount by which payroll retirement taxes have exceeded benefits paid.

The disinvestment of the Social Security trust funds in response to the debt ceiling crisis resulted from the fact that the securities held by the trust funds are part of the total Government debt for purposes of calculating the debt ceiling. When total debt began to approach the debt ceiling, Treasury found itself short of cash and was unable to issue new debt to the public to raise cash. Because Social Security benefit payments must be made each month before the month's payroll taxes are received, the Treasury must use its cash reserves to pay benefits during the first week of the month. The Secretary of the Treasury, who is also managing trustee of the Social Security trust funds, chose to convert long-term securities held by the trust funds into bonds which could be sold to the general public, thus generating cash which was used to pay benefits. In effect, Treasury was able to exchange one form of debt for another without going past the ceiling.

If the special debt issues held by the funds did not count in the calculation of the debt ceiling, Treasury would not have been able to convert the trust fund's holdings into cash. However it would have also prevented the Treasury from making benefit payments as it ran out of cash. This does not necessarily mean that a benefit payment would have been missed, because, when confronted with debt crises in the past, Congress has always provided temporary debt ceiling extensions that allowed payment of benefits. The inclusion of trust fund debt in the debt ceiling merely provided Treasury with a means of delaying the inevitable debt crisis.

However, while Treasury was able to make benefit payments on time in the face of debt crises, its disinvestment of the funds drew criticism for several reasons. First, disinvestment allowed the Treasury to temporarily avoid the effect of the statutory debt ceiling. Second, disinvestment created the impression that Congress was not vigilant in supervising Treasury's management of the trust funds. Third, disinvestment raised fears that the trust funds and payroll taxes were being used to fund non-Social Security programs—an ominous precedent in view of the expected rapid growth in trust fund reserves. Fourth, disinvestment created a general feeling of confusion, with a corresponding loss of confidence in the future of the trust funds. These criticisms have given rise to several proposals to prevent or regulate disinvestment, none of which satisfies all critics.

One suggested solution is to remove trust fund debt from the calculation of the debt ceiling. The attractiveness of this solution is that it provides a simple means of preventing future manipulation of the trust funds without impeding Treasury's ability to conduct routine transactions and investments. It would also further the policy goal of distinguishing the Social Security taxation and benefit process from the balance of the Government's taxing and spending programs.

Furthermore, critics maintain that inclusion of trust fund balances in the debt ceiling does not serve the ostensible purposes of a limit on borrowing by the Treasury. To the extent that the debt ceiling is intended to represent the degree to which Government has financed its programs by borrowing from the private sector, the trust fund balances distort the picture—trust funds merely represent one Treasury account borrowing from another. This distortion will increase in the future because of the expected growth of the surplus in the Social Security retirement fund from the current $33.9 billion to $584 billion in 1995 and over $2 trillion in 2005. The chief argument against removing trust fund debt from the debt ceiling calculation is that it will create the impression that the Government's debt to Social Security is not as important as debt to private bond holders.

Another proposed solution is to continue to include trust fund balances in the calculation of the debt subject to the debt ceiling, but to prohibit any disinvestment that is done to avoid the ceiling. The primary criticism of this approach is that it would prevent the payment of Social Security benefits during a debt ceiling crisis. Proponents of this approach argue that Congress has always raised the debt ceiling in time to forestall cessation of Government activities. Critics nonetheless believe that the payment of benefits should be insulated from the annual debt ceiling crisis in order to prevent needless fear on the part of recipients that their benefits would be suspended.

A third proposed solution would continue to include the trust funds in the calculation of the debt ceiling and would specifically allow disinvestment for the purpose of paying benefits, providing the Treasury notified Congress beforehand. In essence, this would "legitimize" the disinvestment. Proponents believe that this approach would remove fears that the trust funds were subject to unsupervised manipulation by the Treasury, while at the same time, it would use the trust fund reserves to guarantee the payment of benefits in a debt ceiling crisis. Critics believe that this approach still allows the Treasury to evade the debt ceiling, and sets a bad precedent for use of the trust fund reserves.

(C) ADMINISTRATIVE ISSUES IN SOCIAL SECURITY

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission—dignified, high quality service to the public. In the 1950's and 1960's SSA was viewed as an elite agency, marked by high employee morale and excellent management. In the past 15 years, however, many have commented that the agency has lost its esprit de corps, and the quality of public service has declined. Factors cited as causing this decline include new agency responsibilities (for example, the creation of SSI in 1972), multiple administrative reorganization efforts, and the fact that SSA has had 10 different Commissioners in the last 14 years. Many claims that public confidence in the agency has declined in recent years and that the agency has sacrificed the quality of service to the public in an effort to improve efficiency and cut costs.

(1) SSA as an Independent Agency

In the last two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services [HHS]. The National Commission on Social Security, reporting in 1981, recommended an independent agency, as did a majority of the members of the 1983 National Commission on Social Security Reform. Many have recommended that a bipartisan board manage and oversee Social Security, as was the case in the first decade of the program—1935–46. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security, which is by nature a program involving very long-term considerations. It is frequently argued that Social Security, as an entitlement program, should be shielded from short-term partisan politics and bureaucratic infighting, and that administrative independence would enhance public confidence in the program.

As part of the 1983 Social Security Amendments, Congress established the Congressional Panel on Social Security Organization to identify an appropriate method for removing the SSA from HHS and establishing SSA as an independent agency, with its own administrative structure and resposibilities.

The panel's final recommendations to Congress include the following:

—An independent SSA should be headed by a single Administrator, appointed by the President, with the advice and consent of the Senate, to a statutory 4-year term.

—The agency would have responsibility for the OASDI and SSI Program only, not Medicare or Medicaid.

—A permanent, bipartisan advisory board of nine members—five appointed by the President, two by the Senate, and two by the House—would oversee the program, and would make policy recommendations to the Administrator, the President, and Congress.

—The new agency would be delegated certain administrative functions currently handled by the Office of Personnel Management [OPM] and the General Services Administration [GSA] to allow for greater operational flexibility.

In 1986, the House passed H.R. 5050, which contained a plan for an independent SSA. The bill was never reported out of the Senate Finance Committee, although the Senate may hold hearings on the subject if legislation is introduced in 1987. The House plan differed from the panel's in that it proposed a three-person bipartisan board that would exercise SSA's rulemaking authority. The Chief Administrator of SSA would be responsible for operations of the agency and would be appointed by the President.

Both the panel and H.R. 5050 recommended including only Social Security and SSI in a separate agency. Medicare was not included. Opponents of including Medicare in an independent SSA point out that it would be operationally advantageous to have an agency that handles cash benefits only, and that incorporating Medicare which involves third-party intermediaries and a whole different set of administrative tasks, greatly complicates the mission of an independent SSA. Also, in the same sense that it is appropriate to link OASDI and SSI, it is reasonable to want to keep Medicare and Medicaid together, due to the overlap between the programs in clientele, structure, and purpose as public health care financing programs. If both Medicare and Medicaid were to be brought under SSA, it would leave HHS with little responsibility. Some argue that SSA would then be an enormously complex, multi-program agency, with all the problems attendent upon HHS at present.

The various proposals to establish SSA as an independent agency raise a number of important policy issues. Most fundamentally, the question of whether it is necessary to remove SSA from HHS. Sponsors of independent agency proposals often point out that since 1971, SSA has had nine different Commissioners and HHS has had six different Secretaries. SSA has been administratively reorganized a number of times in the past decade, and there has been very little continuity or long-term coherence in leadership and policy. Further, advocates point to major policy debacles that have plagued Social Security in the past 5 years, including the crisis in the DI program created by the overzealous implementation of the continuing disability reviews, and the retroactive elimination, and subsequent restoration of the minimum benefit. It is contended that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security, and more effective in promoting sound policy and administration.

Opponents of an independent SSA point out that most agency problems do not result from SSA's location as a part of HHS, but are rather the result of poor planning and policymaking. Organizational structure may be less to blame than bad leadership, low morale, and ill-considered and voluminous congressional legislation. Some claim that changing an administrative structure will not by itself eliminate the problems of bad policy. This can only be accomplished by appointing intelligent and competent officials, and by Congress making legislative decisions less haphazardly and with greater consideration for the administrative ramifications of statutory changes.

Opponents of an independent agency also argue that an independent agency would not, and should not, put Social Security above policies. A board appointed by the President would not necessarily be politically neutral, nor would a single administrator. In establishing an independent tribunal, with diminished accountability to the President, it is argued that Social Security will be less accountable to the views of the public, and less subject to reform or revision should that become desirable or necessary in the future.

(2) Recoupment of Overpayments

A very specific administrative concern in the recovery of benefit overpayments as revealed in a December 1983 Senate Aging Committee hearing on "Social Security: How Well is it Serving The Public?" Many recipients of Federal benefits elect to have their payments made directly to their bank account by an automatic credit process called electronic funds transfers [EFT]. In cases where these beneficiaries die, but continue to receive benefits, the Federal agency making the benefit payment notifies the Treasury Department that too much money has been credited to the account of the beneficiary. The Treasury Department then seeks to recover payments for the month of death or thereafter by directing the bank where the beneficiary has an account to return the amount owed to the Government. Prior to the 1983 hearing, this process takes place with no advance notice to the beneficiary or joint account holder. In 1983, there were over 300,000 Treasury recoupments involving the use of EFT procedures.

Because banks were required to quickly comply with orders to return money to the Treasury Department, any notice provided by banks usually occurred after the recoupment. This arrangement resulted in cases in which the Treasury Department and the bank erroneously recovered overpayments from EFT accounts without affording the beneficiary or account holder a chance to contest the overpayment claim or to seek a waiver of the recovery, causing much confusion and hardship to some Social Security beneficiaries.

At the close of the hearing, Senator Heinz asked Treasury Department officials to correct the problem by amending the Federal regulations dealing with overpayment collections from direct deposit bank accounts. In response, the Treasury Department issued new regulations, which became final on December 17, 1984.

The new regulations require that banks notify beneficiaries of action to refund erroneous EFT transfers of the Treasury. The notice procedure covers recoupment of Social Security, black lung, SSI, and veterans benefits and civil service, railroad, and military retirement payments. The notice informs the beneficiary that the bank can prevent the recoupment if presented with evidence that the fact of death or date of death is in error. It also advises the account holder that he or she may be eligible for survivor's benefits and that the Federal agency making the payments should be contacted to determine eligibility for benefits.

Although this notice procedures may help to prevent erroneous recoupment by the Treasury as a result of mistaken death reports, it is not intended to help a surviving spouse where the death report is accurate. This is because, while surviving spouses and children may be entitled to payments in their own right, benefits paid in the name of a deceased technically do not belong to his or her survivors. SSA has, in the past continued to seek recoupment of payments made to joint accounts of decedents and their survivors, despite the strong likelihood that SSA will have to make direct benefit payments to these persons in the future. Critics of this practice believe that SSA should treat these payments as mere overpayments, which would allow recipients to request waiver, reconsideration, or manageable repayment schedules.

(3) Closing Field Offices

SSA currently operates 642 district offices, 670 branch offices, 74 resident stations, 2,548 contact stations, and 34 teleservice centers. Recent efforts by SSA to cut back on the number of its field offices and employees has raised concerns that widespread reductions would cause a reduction in the quality of public service. The possibility of service reductions caused by cuts under the Gramm-Rudman-Hollings Act has heightened these concerns.

Critics charge that, in the 1980's, SSA shifted its focus away from the outreach efforts of the 1970's and instead focused on improving efficiency. As a result, many of the smaller and less-efficient field offices opened in the 1970's to increase or improve services have become targets for downgrading or closure. Since 1980, SSA has closed 35 field offices and opended only 4. Another 35 field offices have been downgraded since 1980, while only 16 have been upgraded. SSA has also closed over 600 contact stations since the end of 1982.

The philosophy guiding the SSA cuts was embodied in the 1983 Grace Commission report, which recommended that SSA eliminate 17,000 staff positions and close over 800 field offices, based upon the rationale that operating a single large office in a city of 500,000 to 1 million would be cheaper than operating several small offices. Critics pointed out however, that the Grace Commission's rational rested entirely on cost factors, and failed to assess the effect of closings on the quality of public service.

While most critics recognized that SSA needed to monitor its operating costs closely, and that some offices might have to be closed in order to provide better services, they nonetheless believed that SSA was pursuing cost cutting without regard to the quality of service being provided. Critics also pointed out that SSA often did not consult with members of affected communities before closing field offices. Hearings held in Pittsburgh by the Senate Special Committee on Aging during 1985 highlighted both the lack of communication between SSA and local communities, and the impact of closings on the communities.

(4) Computer Contracts

Although SSA was once a leader in using automation to improve its operations, the last 10 to 15 years have seen its computer systems deteriorate to the brink of disaster. In the early 1980's, this deterioration affected virtually every aspect of SSA's operations, including its organization, management, personnel, and ability to serve the public. In the past decade SSA has made three attempts to upgrade its computer operations, none of which have been completely successful. The current program, begun in 1982, is an ambitious program to completely modernize SSA's computer system.

In the last 4 years, SSA has made considerable progress in its systems modernization plan. By the end of 1986, 20 pilot field offices were using fully automated claims processing techniques with on-line data entry and query. In early 1987, SSA expects to begin acceptance and installation of approximately 1,500 computer terminals per month for installation in its field offices. The new system is intended to eliminate enormous amounts of paperwork and will allow workers in district offices to obtain instant access to the massive benefit and earning records stored at SSA headquarters. Once the system is installed in the district offices, SSA will proceed with modernization of the data storage at its headquarters.

Unfortunately, SSA's progress in modernizing its operations has been marred by allegations of improprieties in the awarding of contracts to various computer companies which serve SSA. In 1984, the Committee on Government Operations of the House of Representatives found that a major data communication contract awarded by SSA to the Paradyne Corp. had been tainted by questionable action on the part of the contractor and inappropriate conduct on the part of SSA officials. In the wake of these revelations, the Government Operations Committee recommended that SSA bar Paradyne Corp. from Federal contracts for 3 years. The SSA official was later convicted of accepting a bribe on a related software contract, and was sentenced to 4 years in prison.

Further controversy arose in 1985 when the Government Operations Committee uncovered improprieties associated with the award of the largest computer consulting contract in SSA's history—a $32 million award naming Electronic Data Systems as prime contractor, and the accounting firm of Deloitte, Haskins & Sells [DHS] as the major subcontractor. Hearings held on November 6, 1985, made public a GAO study which disclosed that DHS received privileged treatment in familarizing itself with SSA operations, and in gaining access to key SSA personnel prior to bidding on the contract. The privileges included providing DHS with office space in the Commissioner's suite for 2 years prior to letting the bids, purchase of meals for SSA personnel by DHS in contravention of rules governing the contract bidding process, and inclusion of DHS personnel in administrative decision making at SSA.

The Government Operations Committee expects to continue its investigation of this contract and other bidding practices and administrative mistakes which have put SSA's modernization program at least 2 years behind schedule and more than $300 million over its original $500 million budget.

Other questions about the systems modernization plan were raised in 1986 reports by the Office of Technology Assessment and the General Accounting Office. While not criticizing the need for, or the overall design of the systems modernization plan, the reports identified a shortage of reliable information about the plan, the needs it was designed to fill, and the effectiveness of the improvements that had already been made. The reports also suggested that SSA might be moving ahead too quickly with the plan—before adequate testing has been done—and might be making excessively large equipment purchases before they are necessary

(D) BENEFIT ISSUES

Social Security has a complex system of determining benefit levels for the 37 million Americans who currently receive them, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes when it believed they were necessary. At present there are a number of specific issues related to the benefit structure that have drawn the attention of Congress.

(1) The Social Security "Notch"

After leveling off in 1985, interest in the Social Security "Notch" persisted at a low level in both the media and in Congress during 1986. Concern about the "notch" became widespread in 1983 after a series of articles by a syndicated newspaper columnist. The "notch" is a difference in monthly Social Security benefits between those born in 1916, and those born in 1917 or later, resulting from a change in the Social Security benefit formula enacted in the 1977 amendments. The difference is substantial only for those in the highest benefit levels who defer retirement until age 65. This problem became noticeable as individuals born in 1917 became age 65 in 1982.

The problem stems from a series of changes the Congress made in the Social Security benefit formula, beginning over a decade ago. In 1972, the Congress enacted automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement, beginning over a decade ago. The intent was to eliminate the need for ad hoc benefit increases, and to fix benefit levels in relation to the economy. However, the method of indexing the formula had a flaw in it in that initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the pre-retirement income of beneficiaries. Before the 1972 amendments took effect, Social Security replaced 38 percent of pre-retirement income for an average worker retiring at age 65. The error in the 1972 amendments caused replacement rates for the average worker retiring at age 65 to rise as high as 55 percent for the cohort born in 1916.

Without a change in the law, the average worker retiring around the turn of the century would have been receiving more in monthly Social Security benefits than he was earning prior to retirement. This projected growth in relative benefits was the cause of the long-run deficit estimated in 1977 at 8.2 percent of taxable payroll. Had the Congress elected to finance this increase rather than reduce benefits, it would have had to double the Social Security tax rate. Instead, in the 1977 amendments the Congress chose to recoup part of the increase in relative benefits and finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high rates of inflation in the late seventies and early eighties made the difference in monthly benefit levels between the cohorts born before and after 1917 greater than intended. The difference became most extreme for those who deferred retirement, particularly those with maximum earnings. For two maximum earners with identical earnings histories, one born in 1916 and the other in 1917, the difference in benefits for retirement at age 62 was only $7 a month. However, these same individuals retiring at age 65 received benefits differing by $111 a month.

Although the notch is actually the result of an over-indexation of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under transition rules, it has been perceived as a benefit reduction by those affected. Individual Members of Congress have responded to the complaints of this group by introducing a series of proposals for relief, most of which would give benefit increases to those born after 1916 at a high cost to Social Security.

(2) Earnings Sharing

Social Security currently provides benefits to women in one of two ways—either as a covered worker in her own right based upon her own earnings record or as a dependent wife, widow, or ex-wife of a covered worker. However, a woman cannot receive both benefits. Therefore, in the case of a one-earner couple, the Social Security benefit provided to a married couple is equal to 1½ times the benefit earned by the employed spouse. In the case of a two-earner couple, the Social Security benefit is based technically on their combined earnings record, but the lower earner's record is subsumed into the dependent-spouse benefit, unless and until that record provides a larger benefit than the dependent-spouse benefit.

This benefit structure was designed when less than 17 percent of married women worked outside of the home and the predominant family pattern was single-earner couples where the woman was the full-time homemaker and marriages were life long. Since mid-century, however, very different social patterns have emerged. The number of two-earner couples, for example, has risen dramatically, as has the number of marriages ending in divorce. Indeed, many of the presumptions upon which the Social Security system was built have changed.

Three distinct groups of women may be considered disadvantaged by the current Social Security system. First, widows whose husbands die early have often been the recipients of reduced benefits for either of two reasons: (1) Their husband's incomplete earnings records yield low benefits; and (2) widows often take actuarially reduced benefits at younger ages.

Second, divorcees are entitled to dependent's benefits based on their last marriage—of 10 or more years duration—and are disadvantaged in two respects. The working ex-spouse may decide to retire early, without consulting his ex-wife and her benefits as a dependent spouse will be reduced. More importantly, if the marriage does not last 10 years, a divorcee is not entitled to a dependent-spouse benefit at all. Where women's work histories have been interrupted by unsuccessful marriages, an insubstantial earnings record and inadequate benefits are the inevitable result.

Finally, two-earner couples are disadvantaged by the current formula for determining benefits. A two-earner couple whose combined earnings equal those of a one-earner couple receive benefits substantailly less than the one-earner couple. This is due both to the additional dependent-spouse benefit to the one-earner couple, and to the fact that the base salary for determining the benefit of the two-earner couple will be the higher earner's salary unless and until the lower earner is entitled, on the basis of her own earnings record, to a benefit larger than that which she would be entitled to as a dependent of the higher earner.

The earnings sharing proposal has emerged as the most popular of several comprehensive plans that would address these equity and adequacy issues. Under earnings sharing, a couple's annual aggregate earnings would be divided equally between them for the purposes of computing a Social Security earnings record. This would effect three principle goals.

First, the individual would be entitled to a Social Security benefit in his or her own right, thus removing any stigma of dependency attached to that benefit. Some argue that the change would merely recognize the value of a woman's work in the home.

Second, it would allow divorced and widowed spouses to build on the earnings records amassed by their former spouses to improve their Social Security benefits.

Third, it would remedy the present inequities between one- and two-earner couples whose identical aggregate income yields unequal Social Security benefits.

Although no earnings sharing bill received serious consideration in 1986, several proposals have been subjects of discussion. The

Social Security Amendments of 1983 required that the Social Security Administration study the costs and the benefits of earnings sharing. That study, and a Congressional Budget Office study looked at three primary alternatives for earnings sharing.

First, the no-loser proposal: Earnings sharing would be used to figure a participant's benefits, only if it afforded higher benefits than current law.

Second, strict earnings sharing: Benefits would be figured under earnings sharing as of a specified date regardless of the impact on the individual participant.

Third, moderated earnings sharing: The percentage of current law benefits guaranteed against earnings sharing would be gradually reduced over a period of 40 years when all participants' benefits would be figured by earnings sharing.

While earnings sharing would remedy the current inequities between one-earner and two-earner couples, preliminary analyses suggest that it is far less effective at improving the adequacy of benefits received by older widowed and divorced women. Since Social Security currently provides a spousal benefit to a divorced spouse after 10 years of marriage—so long as she does not remarry—Social Security benefits based only on the income earned during the marriage might be significantly lower, comparatively. Earnings sharing itself does nothing to remedy the problems of widows benefits under Social Security, except to encourage younger widows to add to the work record amassed by their spouses. To the extent that they do not, they will continue to receive inadequate benefits. While some earnings sharing proposals address this problem by guaranteeing at least current law benefits—the so-called no-loser bills—this adds tremendously to the implementation costs of earnings sharing. Other proposals include a measure allowing inheritance of Social Security credits upon the death of a spouse, which would increase benefits for individuals living along in old age.

It is likely that earnings sharing will continue to receive attention in 1987. However, policy concerns such as the implementation costs, adequacy of benefits to divorced and widowed elderly, as well as the political impracticality of modifying with Social Security so soon after the 1983 amendments will most likely retard the progress of the legislation.

(3) The 3-Percent COLA Threshold

Several recent years of unusually low rates of inflation has focused attention on a Social Security COLA provision that has been in the law since 1972—the 3-percent inflation threshold. The threshold is a provision of the Social Security law that requires that inflation reach at least 3 percent before a cost-of-living allowance is paid to beneficiaries. When inflation is below 3 percent, the COLA is postponed until cumulative inflation since the last COLA reaches or exceeds 3 percent. Thus, 2 years of 2 percent inflation would produce no COLA the first year and a 4 percent COLA the second year.

The threshold was put into the law in 1972, when automatic indexing of benefits began. The trigger was not created, as some believed, as a money-saving device for Social Security, but rather to alleviate the administrative burden for the agency. In 1972, the calculation of benefit increases presented substantial difficulty to SSA, and legislators believed that using the trigger to postpone relatively small increases would prevent numerous administrative problems.

The threshold received little attention after its enactment, primarily because annual inflation in the 1970's and early 1980's stayed well above 3 percent. In essence the threshold was forgotten. In 1984, with inflation dropping, President Reagan proposed that Congress enact a 1-year suspension of the threshold, although inflation remained above 3 percent. The issue also rose in 1985, but again became moot when inflation remained barely above the 3-percent threshold. In 1986, the inflation rate appeared certain to drop below 3 percent, and attention focused on a proposal by Senator Heinz to permanently eliminate the threshold.

The arguments in favor of eliminating the threshold were as follows: First, in an era of low inflation, the issue of paying small COLA's would surface every year and turn into a political football—a result directly contrary to the goal of automatically indexing benefits. Second, with or without the presence of political conflict, the existence of the trigger created uncertainty and insecurity among Social Security recipients regarding their benefits. Third, the trigger had outlived its usefullness—with increasing automation at SSA the administrative problems of calculating and paying small COLA's had practically disappeared. Fourth, a delay of a COLA, even a small one, could have a profound effect on the many thousands of poor or near-poor recipients.

Another factor was the costly "windfall COLA" effect, which is best illustrated by an example. If inflation stayed at 2 percent for 2 successive years, there would be no COLA the first year, and a 4 percent COLA the second year. For most recipients, the 4 percent COLA would accurately compensate for the inflation they had experienced. However, those who retired during the second year would receive a 2 percent windfall as part of their first COLA. This windfall creates a substantial cost because it becomes part of each succeeding benefit check for years. A study by SSA estimated that, primarily because of the windfall effect, the trigger would increase the cost of Social Security by 0.02 percent of payroll annually—an amount equal to $364 million in 1986 terms.

Those opposed to eliminating the COLA trigger believed that it served a useful budgetary purpose by limiting the constant growth of benefit payments. They did not believe that postponing small COLA's would greatly affect beneficiaries. And they believed that the windfall COLA effect should be cured separately, without eliminating the trigger.

2. LEGISLATIVE RESPONSES

For nearly a decade prior to 1983, Social Security occupied the attention of Congress primarily due to the threatened insolvency of the system. In 1983, legislation was passed that restored the financial health of the system's trust funds. With the refinancing of

Social Security it has declined in urgency as an issue, although Congress has continued to take action affecting Social Security.

(A) GRAMM-RUDMAN-HOLLINGS SEQUESTER

Although set in motion in 1985, the automatic budget cuts mandated under the Gramm-Rudman-Hollings Act did not go into effect until April 1, 1986. Social Security benefits and COLA's were exempted from GRH cuts, but the SSA administrative budget was not, so it received the mandated 4.3 percent cut. This reduced SSA's administrative budget by $144 million, from $4.22 billion to $4.08 billion. The $144 million came out of the following areas: $6.2 million from SSA's contingency reserve, which stands by primarily to meet unexpected needs in the disability determination process; $12.3 million came from funds for the computer modernization project; $30 million came from elimination of 1,772 full-time employee positions; $65.1 million from a reduction in overtime and in part-time employees; and $31 million from cuts in travel, training, equipment, printing, and supplies.

(B) ELIMINATION OF 3-PERCENT COLA THRESHOLD

As it became apparent that inflation would not exceed 3 percent in fiscal 1986, Senator Heinz, on May 14, introduced S. 2450 to permanently eliminate the threshold. Although the bill drew some opposition in the press, the elimination of the threshold was assumed in the budget resolution passed by Congress. In July, President Reagan announced his support for complete elimination of the threshold. Both Chambers of Congress added legislation eliminating the trigger to the Omnibus Budget Reconciliation Bill (Public Law 99-509), which was signed into law on October 21, 1986.

(C) DISINVESTMENT OF TRUST FUNDS

Congress was unable to reach agreement on a method to regulate or prevent disinvestment of the Social Security trust funds. The House passed a plan, as part of its independent SSA Bill (H.R. 5050), that would absolutely prohibit any disinvestment during a debt ceiling crisis, even for the purpose of paying benefits. The Senate plan, which it included in both its debt ceiling extension and its Budget Reconciliation Bill, would have regulated disinvestment, but still allowed it for the purpose of paying benefits. Conferees on the Reconciliation bill could not agree on a compromise, so the Senate plan was dropped, leaving disinvestment essentially uncontrolled.

B. SOCIAL SECURITY—DISABILITY INSURANCE

1. Background

In 1986, SSA continued the implementation of the extensive changes mandated by the Social Security Disability Reform Act of 1984. This legislation revised the standards and the process used by the SSA in reviewing the eligibility status of beneficiaries on its rolls. Periodic reviews of DI beneficiaries began as a result of the 1980 DI amendments. Under these amendments, most beneficiaries are reviewed at least once every 3 years, except those designated permanently disabled, who are reviewed once every 6 or 7 years. These periodic reviews are designed to remove from the rolls those beneficiaries who are no longer disabled, or never were disabled, and should not be receiving benefits.

Between March 1981 and April 1984, about 1.2 million case reviews were completed, and just under 500,000 beneficiaries were determined no longer eligible for DI benefits. In other words, 45 percent of those subject to a continuing disability review [CDR] were terminated from the DI rolls. This high termination rate, in conjunction with the fact that two-thirds of those who appealed to an administrative law judge [ALJ] had their benefits reinstated, led to concern that the CDR's were being administered in an improper and unjust manner.

Specifically, critics charged that the CDR's were being conducted hastily and haphazardly, and that the review simply did not render accurate or valid conclusions about a beneficiary's capacity to work. Though the problems with the disability review process are very complex and multifaceted, controversy centered on four key issues: (1) The extent to which persons can be terminated whose disabling condition has not improved, or even worsened, since their admittance to the rolls; (2) the manner in which medical evidence is obtained and evaluated; (3) the great discrepancy in standards of evaluation between ALJ's and State disability examiners, who initially conduct the CDR's; and (4) the degree to which the mentally disabled have been discriminated against by the CDR's.

The various problems with the continuing reviews were the focus of the congressional hearings held by the House Ways and Means Committee, the House Select Committee on Aging, the Senate Committee on Finance, and the Senate Special Committee on Aging. Legislatively, the House and Senate passed differing versions of H.R. 3755 in the spring of 1984. By September, House and Senate conferees had negotiated an agreement, and final legislation was signed by the President on October 10, 1984 (Public Law 98-460).

Prior to congressional action, many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDI's under guidelines that differed from SSA's official policy. At the beginning of 1984, more than half the States were either not processing CDR's, or were doing so under modified standards. This unprecedented rejection of Federal policy is indicative of the magnitude of the crisis created by the CDR's, and suggests that the restoration of order, fairness, and national uniformity to this program will be an enormous challenge in the future.

2. Issues

(A) GROWTH AND CONTRACTION IN THE DI PROGRAM

Virtually all the complicated and esoteric aspects of the controversy in the DI program boil down to one central question; how stringent or lenient do we want to be in the application of the DI program? In Congress some argue that the DI program is a runaway social welfare program, one that has grown far beyond the intentions of Congress, and that SSA's efforts to eliminate large numbers of people from the DI roles is justified. Critics of the CDR's in Congress claim that SSA has been overzealous, and that people who are clearly unable to work are being unfairly kicked off the rolls.

The broad definition of disability coupled with the difficulty involved in making objective determinations of disability, has made the DI program highly volatile, causing it to expand and contract in response to changes in administrative priorities and in response to the administrative climate in which case-by-case adjudication occurs.

(1) The Definition of Disability

When Congress created the DI program in 1954, the definition it chose for "disability" was very strick. It was feared that anything other than a very restrictive definition would lead to high costs and confusion between disability and unemployment. The original definition required that to be eligible one had to be over age 50, insured under Social Security, and be unable to engage in any work by reason of a medical impairment which was expected to be permanent.

Over time the definition has been modified. Between 1954 and 1967, the definition of disability was expanded. In 1958, the coverage requirements were liberalized and dependents' benefits were made available. In 1950, the age 50 requirement was dropped. In 1965, the permanent disability standard was replaced by a more lenient definition: One had to have a disabling impairment expected to last at least 12 months or end in death. This brought under the program those who might recover and return to work, as well as those who were expected to remain disabled until death. In 1967, Congress tightened the definition of disability in response to Federal court decisions requiring SSA to demonstrate that a denied applicant could reasonably expect to find employment in his region of the country.

Since 1967, the basic definition of disability has remained essentially the same. An individual is not considered disabled unless his physical and mental impairments are of such severity that he is not only unable to perform in his previous occupation but cannot, considering his age, education, and work experience, engage in any kind of employment which exists in the national economy, regardless of whether such work exists in the region in which he lives, or whether a specific vacancy exists for him, or whether he would be hired if he applied.

To translate this broad statutory concept into a workable administrative system, SSA has over the years developed an elaborate and immensely complicated scheme of regulations and rules to determine disability on a case-by-case basis.

Though objective in design, the disability determination process remains highly subjective. On the margins, which are very wide, the question arises, do you or do you not give the applicants the benefit of the doubt. In periods of program expansion, the answer tends toward yes, in contraction, no.

(2) The Disability Incidence Rate

Over time, one key indicator of the generosity or stringency of the DI program is the "disability incidence rate," a measure of the number of workers awarded DI benefits in any year as a fraction of the total number of workers insured for DI benefits. Throughout the 1960's, the disability incidence rate was fairly constant, particularly when legislative changes are taken into account. However, beginning in 1970, the disability incidence rate increased by almost 10 percent a year until 1975 when it reached its peak. After 1975, the rate started to decline. This decline became precipitous following 1979. It dropped to an historic low in 1982, during the period of most intensive retrenchment. Social Security actuaries currently project that the disability incidence rate will remain low, though ascending modestly for the next decade.

(a) The expansionary period

Growth in the early and middle 1970's had an enormous effect on the size and cost of the DI program. Between 1970 and 1976, the number of disabled workers almost doubled, while the covered work force increased by only 25 percent. In 1970, annual expenditures under the DI program were $3.3 billion; in 1980, they amounted to $15.9 billion.

A number of factors are usually cited in describing the expansion of the DI program. DI applications increased from 868,000 in 1970 to 1.3 million in 1974, at the same time as the creation of the Black Lung and Supplemental Security Income [SSI] Programs was severely straining SSA's administrative resources. To process these claims, SSA established a number of expedients in the area of development, documentation, and review of claims. The net result of this pressure to process claims may have been a tendency to give the applicant the benefit of the doubt in "gray area" cases.

Another important factor is the social acceptance of disability. Though medical evidence points to no increase in impairments, workers of all ages in the 1970's increasingly claimed that they were disabled. This was compounded by greater public awareness of the availability of benefits, by the creation of SSI, by higher Social Security benefit levels, and by high unemployment.

(b) Program contraction

Beginning in 1978, a major contraction in the DI program began. The disability incidence rate was halved between 1977 and 1982. Despite inflation, DI benefit costs have remained fairly constant between 1981 and 1984, hovering at about $17 billion. The total number of DI benficiaries decreased from a historic high of 4.9 million in 1978 to 3.8 million in 1984.

The most significant factor affecting the decline was the "adjudicative climate" in the DI program. Prodded by criticism from GAO and Congress, SSA made a number of administrative changes to make the eligibility and review process more strict. SSA began reviewing more State agency cases, and returning them to clarify SSA's interpretation of the law. Overall, disciplinary pressures were created to minimize the flexibility of State agency examiners in "gray area" cases.

Legislation enacted in the late 1970's also had an effect. In 1977 Congress substantially increased payroll taxes, and revised the method of indexing benefits. This decreased future benefits, and may have made DI less financially attractive to potential applicants.

The Social Security Disability Amendments of 1980 were broader in scope, and are the explict source of the current controversy in the DI program. The 1980 amendments had been developing since 1974, and were a product of concern that work disincentives, in combination with loose administration and large benefits, were responsible for the growth in the program. The 1980 amendments required SSA to more systematically review State agency performance, as well as that of ALJ's who are often cited as a liberalizing element in the disability determination system.

The provision in the package that has had the biggest impact on the program is the requirement that SSA review the continuing eligibility of beneficiaries at least once every 3 years, except for the permanently disabled.

(B) THE CONTINUING DISABILITY REVIEWS [CDR'S]

Since the inception of the DI program, SSA had the responsibility of continuously monitoring the eligibility of beneficiaries on the rolls. In response to the concern that SSA was not reviewing eligibility carefully enough, Congress included in the 1980 amendments a provision that SSA review eligibility at least once every 3 years.

It should be noted that this periodic review provision was not expected to yield significant savings until 1984. The CDR's were intended to begin on January 1, 1982, with their implementation producing a net savings of only $10 billion in the 4-year period between 1982 and 1985.

A GAO report issued in January 1981 estimated that as many as 20 percent, or 584,000, of the beneficiaries on the DI rolls were either ineligible or receiving too large a benefit payment. The report claimed that SSA's management of the DI program was deficient, and in particular that SSA's procedures for reviewing the disability status of individuals who were likely to have improved were seriously flawed.

On its own initiative, SSA accelerated the implementation of the reviews scheduled to begin January 1, 1982, to March 1981. The accelerated reviews were included as part of the Reagan administration's fiscal year 1982 budget initiatives, and involved reviewing 30,000 additional DI cases monthly beyond the regular review workload. Overall, between March 1981 and April 1984, 1.2 million case reviews were completed, and 485,000 beneficiaries were determined no longer eligible for ID benefits. Not long after the CDR's were implemented in March 1981, congressional concern arose about the quality, accuracy, and fairness of the reviews.

Overall, congressional interest in the controversy associated with the CDR's has centered on a few key issues, discussed below.

(1) Medical Improvement

One of the first problems cited with the CDR's was the fact that beneficiaries were being terminated from the rolls despite the fact that their disabling condition had not improved, or had worsened. In essence, beneficiaries admitted to the rolls under one set of standards were being reevaluated upon a new, more stringent set of standards, and many were being terminated.

The central issue in the debate surrounding the concept of medical improvement is the question of who must bear the burden of proof in the determination of continuing eligibility for DI benefits. A medical improvement standard shifts the burden of proof from the beneficiary to SSA, and it becomes the obligation of the agency to demonstrate that the individual's disabling condition has improved.

(2) Uniform Standards

One of the critical problems in the disability review process is that different levels of review are bound to different evaluational criteria. The fact that ALJ's reverse almost two-thirds of all appeals of State agency termination decisions is the most striking indication of this structural situation.

This lack of administrative uniformity has been exacerbated in the past few years through SSA's policy issuing substantive policy changes through subregulatory means, such as the POMS' internal memoranda, and Social Security rulings. These changes are not open to public comment and review. To the extent that there are ambiguities or substantive conflicts between these subregulatory standards and published Federal regulations, State disability examiners are bound to SSA administrative directives, while ALJ's adjudicate on the basis of formal regulations.

(3) Mental Impairments

The determination of disability for the mentally impaired has proven to be particularly susceptible to swings in the adjudicative climate, due to the inherent difficulty of medically documenting mental disorders. Many mental impairments are diagnosed through indirect, symptomological evidence, and it is often hard to establish through scientific methods the precise nature and degree of the disorder. Further, the disability determination system is oriented toward drawing a sharp distinction between voluntary and involuntary sources of disability, so that only those who are afflicted by a catastrophic, medical condition are awarded benefits, and those who simply may not want to work are excluded from benefits. With mental impairments, it is not always easy to draw clear distinctions between whether one is or is not responsible for the problems, or that one can or cannot control them.

In the early and mid-1970's, large numbers of mentally impaired people were put on the rolls, particularly through SSI. Following the deinstitutionalization of hundreds of thousands of the mentally ill from State hospitals, SSI and DI became major sources of support. With a favorable period of administrative leniency, the benefit of the doubt was frequently given to the mentally impaired, and thousands became entitled to benefits.

When the CDR's began, the mentally disabled were among the hardest hit. At the Senate Aging Committee hearing, GAO reported that although only 11 percent of those on the DI rolls are there because of mental impairments, 27 percent of those terminated by the CDR's were of the mentally disabled category. Further, ALJ reversal rates for mental disability appeals causes were much higher—91 percent—proportionally than for the rest of the disabled population.

(4) Quality of the CDR's

Not long after the CDR's were first implemented, it became clear that there were serious inadequacies in the review process. Without sufficient time, staffing, or resources, State agencies were forced to process far too many CDR's far too quickly.

The phase-in period was much more rapid than intended by Congress, and State agencies sacrificed thoroughness and accuracy for speed and efficiency. As in the mid-1970's, case examiners found themselves under severe pressure to process claims quickly. In this instance, however, the signal from SSA was to deny claims whenever possible.

Another problem cited with the CDR's was their impersonal, paper-oriented character. CDR's were conducted without the benefit of any face-to-face interaction between the beneficiary and the disability examiners. Before the ALJ stage, determinations were based strictly on written evidence.

(5) Multiple Impairments

Another issue of interest to Congress is the role that the combined effect of multiple impairments should play in the disability determination process. Under SSA's administrative practice, if an individual had several impairments, none of which on their own constitute a severe impairment, the individual was disqualified at the first level in the sequential evaluation, the test of a severe or nonsevere impairment. There was no determination of whether vocational factors might be disabling, or whether nonsevere impairments might cumulatively render an individual unable to work.

Critics argued that SSA was violating the meaning of the law in denying a claimant a realistic, individualized assessment of work ability by not evaluating impairments in combination and not examining vocational factors. SSA's categories served to exclude people who, if evaluated in totality, were disabled. Like mental impairments, the combined effects of multiple impairment are difficult to identify medically, and involve what is ultimately subjective judgment.

(6) Pain

As a medical phenomenon, pain is very poorly understood, and has served as an area of contention in the DI program. Until recently, the statute was silent on how it was to be treated in the disability determination system. SSA relied on regulations drafted in 1980 that stated that pain is a symptom, not an impairment, and that its existence alone cannot be used as evidence of disability. There must be medical documentation that shows there is a medical condition that could be reasonably expected to produce the pain. As such objective or subjective evidence of pain is only considered insofar as SSA had identified a cause of that pain.

A number of courts have ruled that this policy is not in conformity with the law, in that pain may be disabling to an individual, regardless of whether its genesis is understood. Severe pain may serve to limit one's ability to perform basic work functions. By not considering pain as a potentially disabling impairment, SSA is not realistically evaluating whether one can or cannot work.

(7) State Actions

A great number of States revolted against SSA's recent practices and policies relating to the CDR's, and many Governors and State agency administrators imposed moratoria on the reviews. States with complete moratoria include Massachusetts, Arkansas, West Virginia, New York, Alabama, New Jersey, Pennsylvania, Michigan, Maine, Illinois, Virginia, North Carolina, Ohio, and New Mexico. Other States initiated temporary or indefinite moratoria. Combined, more than half the States, at the beginning of 1984 were either not processing the reviews, or were conducting them under standards that varied with official SSA procedures and requirements.

This rebellion of the States has been cited by advocates of reforms as an indication of just how completely the DI program disintegrated, and how urgent was the need for comprehensive reform. Opponents of comprehensive legislation viewed this development as a product of the fact the States have no real financial stake in DI benefits, which are paid for in total by Federal funds, and that perhaps federalization of the disability determination is in order.

(C) THE SOCIAL SECURITY DISABILITY BENEFITS REFORM ACT OF 1984

After extensive hearings and consideration of numerous competing proposals, Congress passed a bill which was signed into law on Ocober 9, 1984. The Social Security Disability Benefits Reform Act of 1984 (Public Law 98-640) included the following provisions:

(1) A medical improvement standard to ensure that benefits could be terminated only if substantial evidence showed that the recipient's medical condition had improved;

(2) A requirement that SSA consider the combined effects of mulitple impairments;

(3) A moratorium on mental health reviews until implementation of new mental impairment standards;

(4) Procedural changes requiring pre-termination notices, continuation of benefits during appeal, standards for medical evidence, and other procedural safeguards.

Though the Social Security Disability Benefits Reform Act is a piece of legislation with an unprecedented degree of specificity in the history of the DI program, its ultimate effect will largely depend on how SSA interprets the statutory language, and how this interpretation will translate into administrative instructions and guidance to State agencies.

In concept, a medical improvement standard is a method of ensuring that it the Government is going to declare someone ineligible for benefits, there must be a coherent reason for doing so. In the House version there was a causal link between the change in condition and ability to work. In the final legislation however, this link is broken. SSA determines whether there has been any medical improvement, and if there has been any, it then determines whether the individual can work under current standards. There is no tie between the event—medical improvement—and the outcome—ability to work and hence denial of benefits.

In both breaking the causal link between medical improvement and capacity to work and sidestepping the issue of burden of proof, Congress attempted to establish something that could be labeled a medical improvement standard while evading the central philosphical issues at the heart of the matter. The extent to which the medical improvement standard acts as a procedural safeguard for beneficiaries remains to be seen.

In addition to medical improvement, a few other provisions have the potential for significantly increasing the number of beneficiaries on the rolls. For instance, if the antiquated mental impairments listings are brought into conformity with current medical knowledge, and if an attempt is made to realistically determine whether mentally impaired people can work in a competitive environment, as is required by the legislation, a tremendous number of people might become entitled to benefits.

The provision mandating that SSA consider the combined effect of a multiplicity of impairments could also serve to open doors to applicants and beneficiaries that have been shut in the past few years.

Another major area of uncertainty will be the response of the courts to the legislation. Though the medical improvement application scheme was drafted with the intention of cleaning the judicial slate by sending back to SSA all individual plantiffs, all members of certified class action suits, and all named members of noncertified class action suits, it is very hard to predict what the rule of the courts will be in the future.

(D) REGULATORY ACTIONS IN 1985

Under the mandate of the comprehensive legislation passed in 1984, SSA promulgated three major sets of administrative regulations in 1985. The first set of rules created new standards for evaluating disabilities caused by mental impairments. The rules resulted from extensive interaction between SSA and mental health professionals, particularly the American Psychiatric Association, which led to numerous changes, most notably, an increase in the categories of mental disorders and new standards for medical evidence. SSA published the rules on August 28, 1985 (50 FR 35038).

The second set of rules responded to the mandate of the 1984 reform act and created guidelines for the determination of medical improvement as a prerequisite to the termination of benefits. SSA published these rules on December 6, 1985 (50 FR 50118).

The third set of rules revised the medical criteria applicable to the determination of physical disability. The last revision of the physical impairment criteria had occurred in 1979, and the 1985 rules had been in development since 1982, but had been delayed by the need to write medical improvement and mental impairment rules in response to the 1984 Reform Act. SSA published the new physical impairment rules on December 6, 1985 (50 FR 50068).

While SSA published all of the above rules in 1985, complete evaluation of the rules will not be possible until after SSA has applied the new rules to a substantial number of cases, which will probably not occur until the middle of 1987. Attention will likely focus on the degree of evidence used to establish medical improvement, and the general stringency or leniency with which the rules are applied. In the final analysis, any expansion or shrinkage of the DI program will depend less on the specific language of the rules, and more on the administrative climate which surrounds the application of the rules to individual cases.

3. Legislative and Administrative Response

Congress enacted no significant legislation in the DI area in 1986. This comes as no surprise given the comprehensive nature of the 1984 Reform Act, the regulatory activity that took place in 1985, and the amount of time it will take to measure their impact.

At SSA, the primary task was the continuing implementation of a multitude of changes wrought by the 1984 reforms. During the course of the year, SSA trained the State Disability Determination Offices in the application of the new regulations regarding mental impairments, physicial impairments, and medical improvement. SSA also had to reduce backlogs of initial applications for benefits, CDR's, and cases remanded from the Federal courts.

Because of the large backlogs and its desire to avoid controversy in a highly sensitized area, SSA moved slowly in the implementation of the new regulations. It tended to concentrate on reviewing nonconstroversial cases first. For instance, new CDR's were at first limited to cases classified as "Medical Improvement Not Expected," a classificiation that presents few difficult decisions. Because of this emphasis, no statistics or reliable history developed regarding the rate of approval of new applications for benefits, the rate of discontinuations after CDR's, or the rate of reversal by ALJ's or courts. Until such information becomes available, it will remain impossible to clearly evaluate the impact of the 1984 reforms.

C. PROGNOSIS

In the near term, Social Security policy is likely to remain fairly stable, with few significant issues demanding the attention of the Congress. The 1983 changes in Social Security financing have for the most part guaranteed the solvency of the system and reduced the pressure on Congress to legislate changes in the program to improve its financing. The removal of Social Security from the unified budget will also provide some insulation from program cuts. In addition, the Gramm-Rudman-Hollings Act specifically excludes Social Security from the effect of automatic spending cuts.

However, the drastic nature of the cuts mandated by the Gramm-Rudman-Hollings Act also indicates the degree to which Congress is concerned about the growth of the Federal deficit, and this concern may eventually affect Social Security. Tax increases might eliminate some of the deficit, but, even with tax increases, tremendous pressure will remain on all spending programs. It is possible that, in an attempt to stave off the mandatory cuts of Gramm-Rudman-Hollings, Congress will voluntarily delay or cancel

Social Security COLA's. Congress might also increase the taxation of Social Security benefits, or alter the formulas used to calculate benefits for future recipients.

In the DI program, 1987 may see some attention focused primarily on the implementation and effect of the changes wrought by the 1984 Reform Act. Controversy will likely center around the degree, if any, to which the benefit rolls expand, the efficiency of SSA in handling the large backlog of cases which has accumulated, and the willingness of States to acquiesce in SSA policies with which they disagree.

Over the longer term, there is growing public awareness that the Social Security payroll tax is scheduled to increase in 1988 and 1990. These increases come at a time when Social Security's favorable demographics will contribute to an accumulation of annual surpluses in the OASDI trust fund. In addition, the increase in the payroll tax will take effect as the income tax rates are lowered by the 1986 Tax Reform Act. The result may well be growing public pressure to defer or withhold some of the scheduled tax increases. Resistance to payroll tax increases, coupled with concern about the buildup of large trust fund surpluses may well result in a more thorough effort to reform the Social Security Program in the distant future.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

1986 was the most momentous year for legislation improving pension plans and benefits since the enactment of ERISA in 1974. Major accomplishments included legislation to: Strengthen the financing of the termination insurance program for private single-employer defined benefit pension plans, improve the pension benefits earned by low and moderate income, mobile and short-service workers, enable older workers to continue earning private pension benefits, and provide a new retirement benefit program for Federal workers.

Early in 1986, the Congress voted final approval of the House-Senate Conference agreement on the Consolidated Omnibus Budget Reconciliation Act of 1986 [COBRA], which included legislation to reform the Pension Benefit Guaranty Corporation's single-employer termination insurance program, and raise the premium that funds it. At the same time, the Senate began changes in the tax treatment of retirement plans included in the comprehensive tax reform legislation originally proposed in the President's May 1985 tax reform proposals and passed by the House as H.R. 3838 in December 1985.

Legislation introduced in 1985 to improve retirement income policy and to raise future retirement benefits was included in the tax reform bill in the Senate and remained part of the final version of the comprehensive tax reform legislation passed on September 27, 1986; signed by the President on October 22, 1986.

Late in the 99th Congress, the Senate amended the Omnibus Budget Reconciliation Act of 1986 authorizing funding for fiscal year 1987 with legislation to improve pension benefits for older workers. The act, signed into law as Public Law 99-509 on October 21, 1986, requires that employers extend coverage under their pension plans to workers hired within 5 years of the plan's normal retirement age, and continue to accrue pension benefits for workers after they reach the normal retirement age.

Congress also made major changes in retirement programs for the Federal Government's own employees. The House and Senate Armed Services Committees, after years of debate, agreed upon modifications in the structure of military retirement benefits. The Military Retirement Reform Act of 1986 (Public Law 99-348), signed into law on July 1, 1986, will affect the benefits earned by military personnel entering service after August 1, 1986.

In addition, the Congress adopted a new Federal civilian retirement plan to supplement Social Security for workers hired since

1983. After 2 years of study, the committees of the House and Senate with jurisdiction began work in 1985 on proposals for a new plan. Two different approaches emerged, and the House and Senate conferees worked through the end of 1985 and the beginning of 1986 to develop a final bill. The Federal Employees Retirement System [FERS] was passed on May 22, 1986, and signed into law by the President on June 6, 1986.

By the end of 1986, most of the major retirement income policy issues that have been debated in recent years had been either fully or partially resolved by legislation.

A. PRIVATE PENSIONS

1. Background

Pensions plans are sponsored by employers or unions to provide employees retirement benefits to supplement Social Security. Most pension plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. However, 17 percent of all private plan participants are in multi-employer plans which cover the members of a union while working for any of a number of employers within the same industry and/or region. Today there are over 800,000 private-sector plans with over 40 million private wage and salary workers participating. Just over half (52 percent) of the private wage and salary workers were covered by an employer-sponsored pension plan in 1983.

Most private plan participants (70 percent) are covered under a defined-benefit pension plan. The rest participate in defined-contribution pension plans. Defined-benefit plans specify the benefits that will be paid in retirement, usually as a function of the worker's years of service under the plan or years of service and pay. The employer makes annual contributions to the pension trust based on estimates of the amount of investment needed to pay future benefits.

Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on his length of service and pay. Fewer than a third (30 percent) of all participants in medium and large size private plans receive benefits based on a fixed dollar amount for each year of service. Most fixed dollar plans cover union or hourly employees and are collectively bargained between the union and employer. The majority of pension plan participants are in salary-related plans that base the benefit on a fixed percentage of career average pay or final 3 or 5 years pay.

Workers in private-sector defined-benefit plans are typically in large plans provided as the primary pension plan, funded entirely by the employer. More than three-quarters of the participants in defined-benefit plans are in plans with more than 1,000 participants. The defined-benefit plan where it exists is either the only pension plan the employer offers or the primary plan. The largest employers generally supplement the defined-benefit plan with one or more defined-contribution plans. Where supplemental plans occur, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined-contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, less than 3 percent of the contributions to defined-benefit plans come from employees. Most of those contributing to their pension plans are government employees.

Defined contribution plans specify only a rate at which annual or periodic contributions are made to an account. Benefits are not specified but are a function of the account balance, including interest, at the time of retirement. All defined-contribution plans are not strictly speaking "pension plans," in that they are not all intended solely to provide retirement income, although they are all included in ERISA and Internal Revenue Code definitions of plans subject to tax-qualifications and fiduciary requirements.

Private pensions are provided voluntarily by employers. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly-paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers deduct their contributions currently even though they are not immediate compensation for employees; (2) income is earned by the trust tax-free; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantage, however, is the tax-free accumulation of trust interest ("inside build-up") and the fact that the benefits are usually taxed at a lower rate than contributions would have been when made.

In the last decade the Congress has increasingly used the special tax treatment as leverage to enforce widespread coverage and benefit receipt. In the Employee Retirement Income Security Act [ERISA] of 1974, Congress first established minimum standards for pension plans to ensure broad distribution of benefits and limited pension benefits for the highly-paid. ERISA also established standards for funding and administering pension trusts, and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

In 1982, Congress sought in the Tax Equity and Fiscal Responsibility Act [TEFRA] to prevent the fact of discrimination in small corporations by requiring so-called "top heavy" plans (i.e., plans in which the majority of plan assets benefit "key" employees) to accelerate vesting and provide a minimum benefit for short-service workers.

In 1984, Congress enacted the Retirement Equity Act [REA] to improve the delivery of pension benefits to workers and their spouses. REA lowered minimum ages for participation to 21, provided survivor benefits to spouses of vested workers, and clarified the division of benefits in a divorce.

As of 1985, private pension funds totaled $917 billion and accounted for 42 percent of the institutional assets in the economy. In 1986, Federal tax expenditures for public and private employer-sponsored pensions cost the Government $71 billion.

2. ISSUES

(A) BENEFIT ADEQUACY

The goal of retirement plans is to replace a worker's preretirement earnings with sufficient benefits to maintain his or her standard of living into retirement. The President's Commission on Pension Policy recommended in 1981 that to achieve this goal, the worker earning the average wage would need income from pensions, Social Security, and other sources equal to 60 to 75 percent of preretirement earnings.

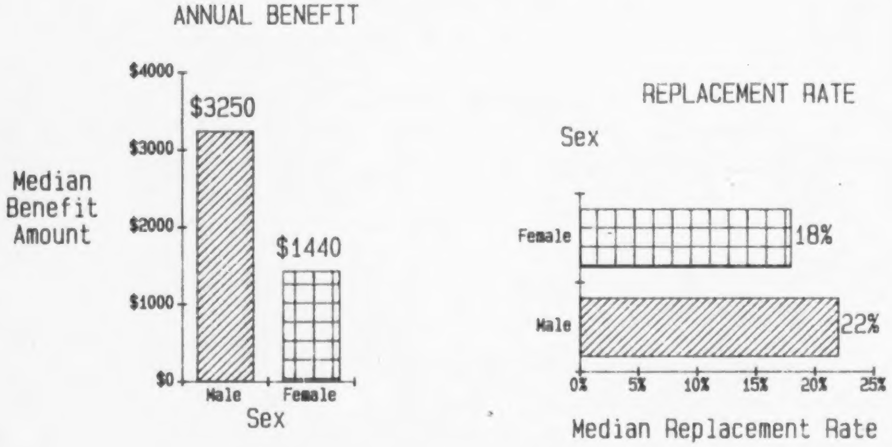
The President's commission also recommended that "replacement ratios" for low wage earners should be higher than for high wage earners. The replacement ratio needed to maintain a reasonable standard of living declines with higher earnings because it is thought that the highly-paid can live with a lower percentage of their income more easily than the low-paid who already use nearly all of their income to consume necessities.

Pensions are usually intended to add benefits to Social Security to bring workers' retirement incomes up to an adequate level of income replacement. Because Social Security provides a higher replacement to low earnings workers (25 percent), pensions often "tilt" their benefits the other way—providing a higher replacement to the higher paid. For example, a minimum wage worker receiving 54 percent of preretirement earnings from Social Security would only need to replace 20 to 35 percent of preretirement earnings from a pension to meet the Pension Commission's goal of 75 to 90 percent replacement. On the other hand, a worker paying the maximum Social Security tax (with 25 percent replacement from Social Security) would need to replace 35 to 50 percent of pre-retirement earnings from a pension.

Older Americans today receive relatively little income from pensions. Three-fourths of those 65 and older receive no pension benefits. Only 15 percent of the income the elderly receive in total comes from pensions. Average benefit levels from pension plans tend to be low. A Labor Department study of recent retirees from private pension plans projected the median annual benefit of 1977-78 retirees from the plan to be $2,650. This benefit replaced, at the median, 21 percent of pre-retirement earnings. Benefit levels for women were even lower—the median annual pension for women was 44 percent of that for men, largely due to lower career earnings.

CHART 2-1

MEDIAN PENSION BENEFITS FROM FINAL PENSION PLAN BY SEX
WORKERS RETIRING WITH PENSIONS IN 1977-78



SOURCE: U.S. Department of Labor, Office of Pension and Welfare Benefit Programs. Private Pension Benefit Levels. (Washington, D.C.: GPO) June 1985

The generation of workers retiring today are benefiting somewhat more from the pension system than previous retirees. Nearly half of the families who retired on Social Security in 1980 and 1981 are receiving some income from pensions, although one-half of these receive less than $400 a month in benefits from all their pensions combined.

Three factors are most likely to cause low pension benefits: movement in and out of the labor force or pension-covered employment, job mobility and the length of stay on any one job, and features of pension plan formulas that may reduce pension benefits.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The Labor Department study found that the median benefit for workers with 10 years of service under their last pension plan replaced only 6 percent of their pre-retirement income while the median benefit of those with 35 years of service replaced 37 percent of pre-retirement income. Similarly, workers who entered the plan at a young age accumulated larger pensions than those who entered the plan late in life.

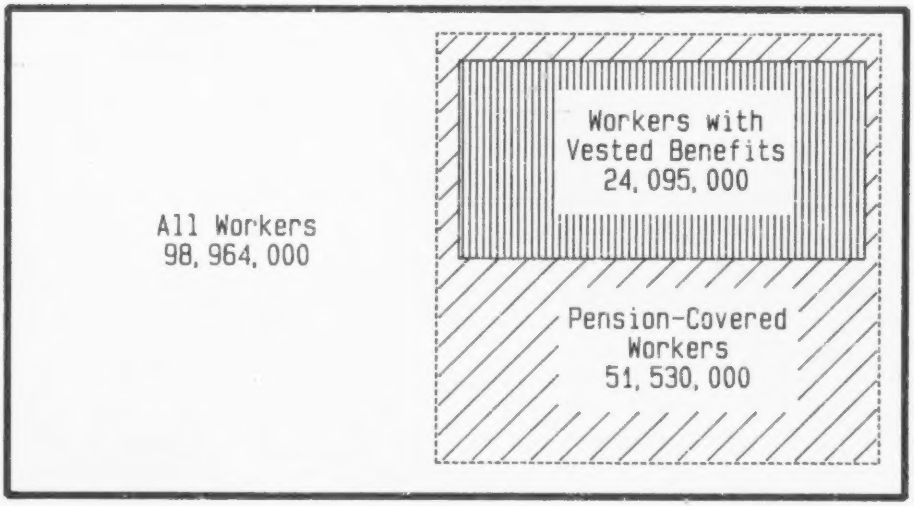
(1) Coverage

Employers or unions voluntarily sponsor pension plans to provide workers with benefits supplementing Social Security in retirement. Today only half (52 percent) of all American workers are covered by a pension plan sponsored by their employer. In total, 47 million workers are not covered by a pension plan, either because they work for an employer who does not have a pension plan, or because they are excluded from participating in the employer's plan.

Employers who offer pension plans do not have to cover all of their employees. The law governing pensions—ERISA—permits employers to exclude part-time, newly-hired, and very young workers from the pension plan. In addition, the law has required employers to cover, at most, only 70 percent of the remaining workers (only 56 percent if employees must contribute to participate in the plan); and an even smaller percentage of workers if the classification of workers the plan excludes does not result in the plan discriminating in favor of the highly-paid.

CHART 2-2

PENSION COVERAGE AND VESTING
TOTAL U.S. WORKFORCE
MAY 1983



SOURCE: Emily S. Andrews. The Changing Profile of Pensions in America (Washington, D.C.: EBRI) December 1985.

Most noncovered workers, however, work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms tend not to provide pensions because a pension plan can be administratively complex and costly, often these firms have low profit margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projections of future trends in pension coverage have been hotly debated. The expansion of pension coverage has been slowing steadily over the last few decades. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. In recent years, coverage has actually declined slightly due to recession, the loss of jobs in well-covered manufacturing sector, and the increase in jobs in the poorly-covered service sector. It is unlikely that pension coverage will grow much without some added incentive for small business to add pension plans and for employers to include currently excluded workers in their plans.

(2) Vesting

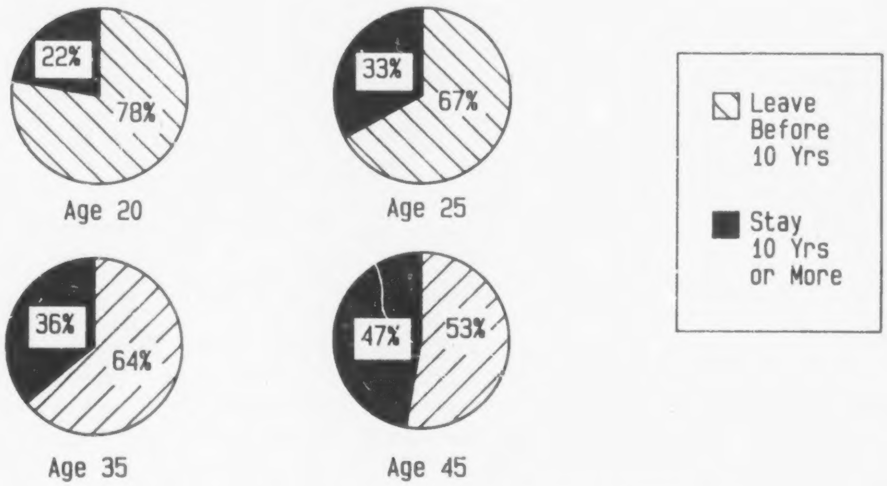
Vesting is earning the right to receive benefits from a pension plan. Someone who is merely covered by a pension plan will not necessarily receive benefits from that plan. To receive a benefit the worker must vest under the plan.

Vesting is one of the features of a pension plan intended to encourage employees to stay with the company. Hiring and training workers can be costly to employers. To reduce job turnover and keep good workers, employers often hold out the promise of better compensation in the future. A pension is one way for a company to systematically reward worker loyalty without causing resentment among other workers.

Vesting provisions are a simple way to make sure benefits do not go to short-term workers. Because the rules are clear to workers, vesting rules have been shown to be effective in reducing the rate of job quits among those who are a few years short of vesting.

CHART 2-3

PERCENTAGE OF FULL-TIME MALE WORKERS REMAINING ON THE JOB TEN YEARS
BY AGE OF JOB ENTRY



SOURCE: David L Kennell and John F. Sheils, Revised Documentation of the ICF Pension and Retirement Simulation Model (Washington, D.C.: ICF Incorporated) February 1984.

Most workers today do not stay with the same employer the number of years required to earn a benefit in their pension plans. ERISA required that plans provide for vesting under one of three minimum standards. The standard used most frequently permits no vesting for the first 10 years of employment with full vesting upon the attainment of 10 years of service. Nearly 80 percent of pension-covered workers are covered by plans that do not fully vest (provide a nonforfeitable right to a benefit) before 10 years, and more than 60 percent are in plans that vest no benefit before 10 years. The probability that a worker starting a job will remain on this job for 10 years is low. Full-time male workers have the longest average job tenures; and even then, only one male in two starting at age 45, will stay 10 years.

Workers today are having a more difficult time earning pensions than their predecessors because job tenure is on the decline. The average job tenure for a male aged 40–44, for example, has dropped from 9.5 years in 1966 to 8 years in 1981. Women's average job tenures are declining less rapidly—but already tend to be much shorter than men's. Job tenure for women aged 40–44 dropped from 4.1 years in 1966 to 3.9 years in 1981.

(3) Benefit Distribution and Deferrals

When workers change jobs, earned pension benefits can be lost. As a result, much of the money being accumulated for retirement is not being retained to provide retirement income.

Vested workers who leave an employer before retirement usually have the right to receive "vested deferred benefits" from the plan when they reach retirement age. Benefits that can only be paid this way are not "portable" in that the departing worker may not transfer the benefits to his next plan or to a savings account. Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits.

Federal policy on lump-sum distributions has been inconsistent. On the one hand, Congress in the past encouraged the consumption of lump-sum distributions by permitting employers to make mandatory distributions without the consent of the employee on amounts of $3,500 or less; and by providing favorable tax treatment through the use of the unique "10-year forward overaging" rule (permitting the tax payment to be calculated as though the individual had no other income). On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account [IRA] within 60 days.

IRA rollovers appear to have been largely ineffective. To the extent that workers receive lump-sum distributions, they tend to spend them rather than save them; thus distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lum-sum distributions are saved in a retirement account, and only 32 percent are retained in any form, including the purchase of a home. Even among older and better educated workers, fewer than half roll their pre-retirement distributions into a retirement savings account.

Even when they vest, workers lose pension benefits under some plans when they change jobs. The pension loss results from the way some plans accrue benefits. Final-pay formulas have been popular with employers because they relate the pension benefit to the worker's earnings immediately preceding retirement. However, final-pay plans penalize workers who leave the plan before retirement by "freezing" benefits at the last pay level under the plan. The younger a worker is and the further from retirement, the less valuable the pension benefits will be. A mobile worker earning benefits under a number of final-pay plans will receive much lower beneifts than a steady worker who spends a full career under a single plan.

(4) Pension Integration

Current rules permitting employers to reduce pension benefits to account for Social Security benefits can result in an excessive reduction or even elimination of a lower-paid worker's pension benefits. Under the Social Security Program, workers pay a uniform tax rate but receive Social Security benefits that are proportionately higher at lower levels of income. Employers who want to fit their pension benefits together with Soical Security benefits to acheive a more uniform rate of income replacement for their retirees use integration to accomplish this goal. The integration rules define the amount of adjustment a plan can make to pension benefits before the plan is considered discriminatory.

In the past, pension integration could be used unfairly and could deprive workers of legitimate benefits. In general, there are two types of integration—excess and offset. In excess integration, the plan pays a higher contribution or benefit on earnings above a particular level (the "integration level") than it pays on earnings below the level; current rules permit the plan to make no contributions below the integration level. In offset integration, the plan reduces the pension benefit by a percentage of the Social Security benefit; current rules limit the percentage of Social Security that can be used but do not prevent the elimination of the pension altogether. Current rules are also out-dated and overly complex. They make it extremely difficult for pension participants to understand what is happening to their pension benefits.

(B) TAX EQUITY

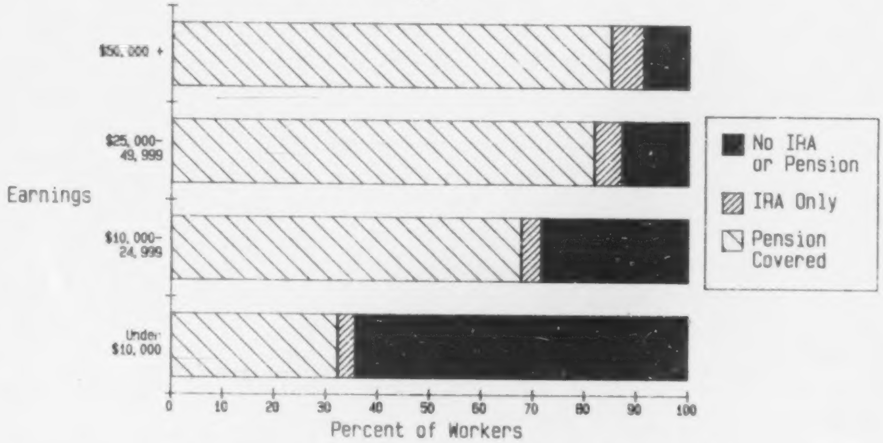
Private pensions are encouraged through tax benefits now estimated by the Treasury to equal $53 billion in 1986. In return, Congress regulates private plans to prevent overaccumulation of benefits by the highly paid. Efforts to prevent discriminatory provisions of benefits have focused recently on the potential for discrimination in voluntary group savings plans and on the effectiveness of current coverage and discrimination rules.

In recent years, there has been a substantial increase in tax-free individual contributions to retirement and savings plans. Prior to 1974, only employees of public or tax-exempt organizations could elect to defer some of their salary without paying income taxes on it through a tax-sheltered annuity [TSA] as established under section 403(b) of the Internal Revenue Code. Private sector employees could make only after-tax contributions to a retirement plan. Beginning in 1974, the Congress gradually extended the opportunity to make tax-free elective deferrals to all employees. Legislation was enacted in 1974 permitting workers not covered by a employer-sponsored pension plan to defer up to $2,000 a year to an individual retirement account [IRA]. Then, in 1978, cash or deferred arrangements [CODA's] were authorized for private employers under section 401(k). Workers covered under a CODA may make elective tax-free contributions (by agreeing with the employer to reduce their salaries) to an employer plan. The amount that any worker could contribute was limited by the total limit on all pension contributions (25 percent of salary up to $30,000) and by a separate nondiscrimination test for 401(k) plans restricting the average percentage of salary deferred by highly-paid workers to 150 percent of the average percentage of salary deferred by lower-paid workers. Finally, in 1981 Congress opened up the opportunity to defer $2,000 a year in an IRA to all workers.

Concern has grown in recent years that tax-free voluntary savings may offer too great a tax shelter for the highly-paid and may be inequitable. The tax benefits of voluntary savings are most attractive to those in the highest tax brackets. While a large portion of the tax benefit goes to those who would probably save for retirement without it, many who needs the retirement savings do not benefit from the tax provisions. In addition, there is some concern that the aggressive tax expenditures to encourage saving has become excessive. For example, the majority of those using IRA's in the past were also participating in a corporate pension or 401(k) plan.

CHART 2-4

COVERAGE BY RETIREMENT PLANS
BY EARNINGS
1983



SOURCE: Emily S. Andrews, The Changing Profile of Pensions in America (Washington, D.C. EBRI) December 1985.

Nondiscrimination rules are intended to ensure that employee benefit plans that are tax-favored are of benefit to a broad cross-section of employees and not just the highly-paid. Corporate pension and deferred compensation plans are required to meet a number of nondiscrimination tests for coverage and comparability of benefits as set forth in sections 401 and 410 of the Internal Revenue Code (and various revenue rulings) to become tax-qualified.

Plans are required to benefit either 70 percent of the employees who meet age and service requirements (56 percent in a contributory plan) or a classification of employees that the Secretary of Treasury finds not to be discriminatory. Benefits provided in one or a number of plans by the same employer must be reasonably "comparable" (in relation to pay) at various pay levels.

CODA's, in which participation is optional for the employee, must meet an additional nondiscrimination test based on the use of the plan, to ensure that the highly-paid are not benefiting disproportionately from the plan. Under current law, the top one-third of employees, by pay, cannot defer more than 1.5 times the average proportion of salary that the lower-paid two-third actually defer.

In the last few years, there has been growing concern that the current coverage rules are too loosely structured and have been weakened too much through revenue rulings to ensure broad participation in employer plans by lower paid workers. In addition, there has been some concern that the current CODA discrimination rules permit excessive deferrals by the highly-paid in relation to the amounts actually deferred by the lower-paid. Tax-sheltered annuities have not been exempt from nondiscrimination requirements for tax qualified plans since these were established under a separate code section (section 403(b)).

(C) PENSION FUNDING

The contributions plan sponsors set-aside in pension trusts are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 [ERISA], regulates the level of funding and the management and investment of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined benefit plans) must have enough assets to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Plans created since 1974 are required to reach full funding within 30 years. Plans predating ERISA were allowed 40 years to develop full funding. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," and prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined benefit plans. This program guarantees benefits up to $1,858 a month (1987) (adjusted annually). As of 1985, the single-employer program was funded through annual premiums of $2.60 per participant paid by employers to a nonprofit Government corporation—the Pension Benefit Guaranty Corporation [PBGC]. When an employer terminated a plan, the PBGC received any assets in the plan, and made a claim against additional assets up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multiemployer defined benefit plans, using a slightly higher annual premium, but guaranteeing only a portion of the participant's benefits.

Changes made in the PBGC in 1986 focused on three concerns about pension funding. The most pressing concern was increasing termination of plans with large unfunded liabilities and the resulting need for reform and a premium increase for the single-employer termination insurance program. In addition, there was a growing concern about the termination of overfunded plans by employers to recover excess pension assets.

(1) Termination of Underfunded Plans

Over the last 5 years, there has been increasing concern that the single-employer termination insurance program, operated by the PBGC, is inadequately funded. The PBGC began to seek congressional approval for a premium increase in May 1982. By the end of fiscal year 1984, PBGC had liabilities of $1.5 billion and assets of only $1.1 billion—leaving a deficit of $462 million. Projections at that time indicated that without a premium increase the fund for single-employer plans would be exhausted by 1990. During 1985 the PBGC assumed $615 million in additional liabilities. By the end of fiscal year 1985, the PBGC reported liabilities of $2.7 billion and assets of only $1.4 billion—leaving a deficit of $1.3 billion.

The Congress responded to a much smaller deficit in 1978 by simply raising the annual premium from $1 to $2.60 per participant. This time, however, employers, labor organizations, and the administration worried that the program itself was flawed, and without reform, premium increases could be never-ending.

A major cause of the PBGC's problems was the ease with which economically viable companies could terminate underfunded plans and dump their pension liabilities on the termination insurance program. Employers unable to make required contributions to the pension plan were requesting "fund waivers" from the Internal Revenue Service [IRS], permitting them to withhold their contributions, and thus increase their unfunded liabilities. As the underfunding grew, the company terminated the plan and transferred the liability to the PBGC. The PBGC was helpless to prevent the termination, and was also limited in the amount of assets that it could collect from the company to help pay for underfunding to 30 percent of the company's net worth. PBGC was unable to collect much from the financially troubled companies since they were likely to have little or no net worth.

Terminations of underfunded pension plans have also reduced the benefits paid to participants and beneficiaries. Even though vested benefits are generally insured by th PBGC, the termination insurance program does not protect all benefits vested in underfunded plans. Employees are often in a difficult position when an employer terminates an underfunded plan. On the one hand, termination will result in a loss of benefits. On the other hand, the inability of the company to restructure its debt may force the company to go out of business and the workers to lose their jobs.

In the last 2 years, the PBGC assumed the three largest claims in the program's 11-year history—all of which have illustrated fundamental weaknesses in the termination insurance program. In July 1985, the Allis-Chalmers Corp. ended its pension fund with liabilities of $165 million and assets of only $5 million, having managed to fund only 3 percent of the benefits it promised. In October 1985, the Wheeling-Pittsburgh Steel Corp., which had filed the previous April for reorganization under chapter 11 of the Bankruptcy Code, announced its intention to terminate its two pension plans, with unfunded liabilities of over $450 million. In September 1986, the PBGC terminated LTV Corp.'s pension plan for salaried employees in their Republic Steel Division. LTV, which had filed for reorganization under chapter 11 on July 17, announced at the same time their intention to terminate the plan for salaried employees in their Jones & Laughlin Division in January 1987. In all cases, the companies may become or remain profitable in the future, in part because they have succeeded in dumping pension liabilities on the PBGC. The result is that participants in the companies' plans (through some loss in benefits) and the companies' competitors (through higher premiums to the PBGC) will subsidize the future profitability of these companies.

Criticism of the termination insurance program focused on four issues: First, should companies that are not in financial hardship be able to terminate an underfunded plan and dump liabilities on the PBGC? Second, if a company requests a "funding waiver," should they be required to put up some type of security for the reduced contribution? Third, if a company avoids its pension liability by selling or transferring a financially troubled subsidiary, should the PBGC be able to make a future claim against the parent company if the plan is later terminated? Fourth, should a company that terminates its plan in financial distress have additional liability to the PBGC if they later become profitable?

(2) Reversions of Assets From Termination of Overfunded Plans

Concern in the Congress continued in 1986 over the termination of well-funded defined benefit pension plans to enable plan sponsors to recapture the surplus assets. Under ERISA, sponsors of plans with assets that exceed ERISA funding standards can recover these surplus assets over time by reducing their contributions to the plan. Withdrawals of assets are not permitted as long as the plan remains in operation. Employers can recover assets, however, when a plan is terminated.

In recent years, a substantial increase in plan surpluses due to bond and stock market gains and an increasing awareness of the potential for recovering plan assets, has caused employers to consider terminating well-funded defined benefit plans for a variety of business reasons unrelated to the purposes of the retirement plan. The major reasons for termination have included: Financing or fending off corporate takeovers, improving cash flow or redirecting the company's assets, and modifying the company's retirement income plans.

Originally, employers were loathe to terminate pension plans simply to recover assets because of a concern that plan participants might lose benefits and the PBGC would prevent them from offering a similar successor plan. The issuance of Implementation

Guidelines for Asset Reversions by the PBGC, Treasury Department, and Department of Labor in May 1984 helped clarify that an employer could terminate one plan and establish a similar successor plan as long as all plan participants were vested and benefits were fully covered under annuity contracts. This clarification has given rise to a host of new plan terminations that have left participants covered under identical or similar successor plans.

The number and size of reversions from plan terminations has increased steadily over the first half of this decade. Only in late 1986 has there been any moderation in this trend. Since 1979, 1,220 pension plans have terminated with a reversion of nearly $12 billion in excess assets. These terminations affected more than 1.4 million participants.

The number of pension plan reversions was down dramatically in 1986 as compared to 1985. In 1985, 536 plans involving 632,638 participants were terminated with a total of nearly $5.5 billion in excess assets reverted to employers. In 1986, employers received total reversions of excess assets of $731 million from 63 plans covering 77,424 participants. This trend downward may not continue, however, as the PBGC had 75 additional plan termination requests pending as of February 1987, which if approved, would result in reversion of over $1 billion in assets. Reversions from the termination of defined benefit plans are likely to continue to accelerate due to the substantial excess in pension funding. Currently, the 200 largest companies by sales have an estimated $73 billion in liquid pension assets.

Employers who are terminating pension plans to recover assets usually set up a replacement plan to continue pension coverage for participants. Data from the PBGC on pending terminations as of September 1985 shows that in 85 percent of the proposed plan terminations, the participants were to remain covered under the old or a successor plan. In half of the cases, coverage continued under a defined benefit plan; in a third of the cases, participants were covered under a defined contribution plan.

The two common methods for leaving participants covered under a defined benefit plan—"spinoff" termination and "re-establishment" termination—essentially leave participants benefits unchanged. Under a "spinoff," the old pension plan is split into two plans—one covering retirees and the other active employees. Active employees remain in the old plan. The surplus assets are placed in the retiree plan, the retiree plan is terminated, and annuities are purchased for the retirees. Under a "re-establishment," the old pension plan is terminated and a new similar plan is set up, with past service credits normally provided in the new plan for all active employees. By using either approach, employers are doing in two steps what they would not be allowed to do in one step. Many have argued the "step transaction doctrine" whereby if actions taken in two transactions have basically the same result as could have been obtained in a single transaction, which would have been disallowed, then the two transactions should not be allowed. However, if the "doctrine" is applied, the employer will then have a strong incentive to completely terminate the plan with no form of re-establishment. There is agreement that defined benefit plans are advantageous for employees and that their continuation is to be encouraged. The extension of the argument is that the plan sponsors not be forced into a position whereby they have to "play games," and further that the current two-step withdrawal be allowed in one step, thereby eliminating the necessity to terminate the existing plan. Since benefits often remain unchanged, there is disagreement over whether reversions are in fact a serious problem. Critics argue that retirees can be harmed in a spinoff termination because they lose the potential for future cost-of-living increases in their benefits. They also contend that reversions draw needed, as well as surplus, assets from the plans and may increase the risk for the PBGC because newly created plans are not required under ERISA to maintain a funding level as high as plans that have been in existence for some time.

Plan sponsors counter that the real problem is that employers have to terminate pension plans in order to recover surplus assets they should be able to have without termination. Since the company, in a defined benefit plan, promises specified benefits to employees, only the benefits earned to date—not the assets in the plan—belong to participants. Employers are responsible for adequately funding these benefits and should be permitted to recover funds not needed to pay benefits. Under current law, employers can reduce their contributions to recover surpluses over time. Employers argue they should not have to wait.

Some of the assets recovered in a defined-benefit plan termination would not be surplus assets if the plan was going to continue. Some observers have suggested that the recovery of these additional assets is weakening the funding of pension plans and undermining the purpose of the ERISA funding standards. They have proposed that sponsors should be permitted to recover the assets not needed on a continuing basis but be prevented from recovering additional assets if they are going to continue coverage for their employees under a successor plan.

(3) Investment Performance of Pension Funds

Over the last few decades, pension funds have become one of the largest single-purpose pools of capital in the economy. As of September 30, 1986, the Employee Benefit Research Institute estimated that the assets in private trusted pension funds had grown to $1.015 trillion—an amount representing approximately 54 percent of all private, State, and local pension assets. These funds are becoming increasingly important, not just to the 75 million workers who depend upon them for future retirement income, but for the economy and investment strategies as well. While the investment performance of these pension funds is important, increasingly these funds are becoming a focus of other policy concerns as well.

In January 1985, the Department of Labor held a series of hearings on investment and governance issues related to private pension funds. The published conclusions from these hearings noted that pensions are becoming a dominant factor in stock trading markets. The growth in pension funds were viewed as coincident with an increase in daily trading on the Stock Exchange, annual turnover rates of up to 70 percent of pension funds a year, and a growing trend toward corporate takeovers. As the decisionmaking about pension fund investment has taken on more significance in the context of general corporate finance, there is a growing concern that the relationship to retirement income delivery is weakening. The concern is the extent to which ERISA's restrictions of pension fund investment—the "prudent man" rule and prohibited transaction restrictions—may be compromised by the rush to "put the money to good use."

Attention has begun to focus on the performance of pension funds relative to that of other institutional investors. There is a growing perception that pension funds have generally done poorly and that money managers are failing to achieve above average returns on their clients' funds. Date prepared by the Employee Benefits Research Institute [EBRI] shows that although pension fund investment return on bonds has exceeded the Lehman Index over 3 years from 1983 to 1986, the performance of equity portfolios lagged the Standard and Poors 500 over the same period. SEI Fund Evaluation Services data shows that nearly three-quarters of the pension fund money managers failed to out perform the Standard and Poors 500 index in 1984, and over the last decade, the majority (56 percent) of money managers have failed to outperform the S&P 500. Plan sponsors pay $6 billion a year to money management firms to outpace the market, yet most fail to achieve even average returns. With plan sponsors eager to produce high returns and most money managers having difficulty consistently outpacing the market, plan sponsors have engaged in a flurry of account switching and stock-churning. The switch in managers itself can eat up 1 to 2 percent of the value of this account. The net result has been high transaction costs and low yields. Some plan sponsors have begun to pursue more conservative investment strategies, such as buying portfolios that match the composition of the S&P 500, in an effort to improve on poor returns.

A final investment issue has been whether the vast pool of pension assets should be directed to serve social purposes, quite apart from the purpose they now serve in providing retirement income. Generally, social investments are investments that earn a lower rate of return than they might otherwise but which further a particular social end. Alternatively, social investments may be strategies that focus on placing capital where it is needed—possibly at a higher risk and with a potentially high yield—for economic reasons beyond those of improving fund performance. In both cases, the future benefits of participants are put partially at risk to serve goals beyond those of providing retirement income. In recent years, there has been pressure on the Department of Labor to make it easier—through comprehensive plan asset regulations—to invest in real estate, venture capital, and oil and gas partnerships. As the pool of pension funds grows, the pressure to use these assets for social purposes increases.

3. LEGISLATION

(A) TAX REFORM ACT OF 1986 (PUBLIC LAW 99-514)

Pension changes proposed as part of tax reform dominated the pension agenda throughout 1986. The effort to reform the tax code to improve its fairness and simplicity began in earnest with the release of the Treasury Department's report to the President in November 1984. Recommendations included in the report were modified and incorporated in the President's Tax Proposals issued in May 1985. A subsequent set of proposals, prepared by the staff of the Joint Committee on Taxation, were provided to the chairman of the House Ways and Means Committee in September. These proposals became the basis for the committee's markup of a tax reform bill from September through November. On December 3, the House Ways and Means Committee reported H.R. 3838, the Tax Reform Act of 1985, which was passed by the House on December 17 and sent to the Senate.

At the same time, legislation aimed at improving future retirement benefits was introduced in the Senate by Senators Heinz and Chafee (S. 1784) and in the House by Representative Clay (H.R. 3594) on October 22, 1985. The Retirement Income Policy Act [RIPA] was intended to strengthen employer-sponsored and financed retirement plans, to support voluntary savings as a supplement to employer-financed plans, and to encourage employer plans to meet the needs of workers with a variety of career patterns. The bill included provisions to expand pension coverage, improve benefits for short-term and low-paid workers, simplify pension rules where possible, and focus tax incentives on encouraging fundamental retirement income programs. Hearings were held on the bill in the Senate Finance Committee January 28 and in the House Education and Labor Committee February 27, 1986.

Many of the RIPA pension provisions were incorporated in the Tax Reform Act by the Senate Finance Committee. The Finance Committee began markup of H.R. 3838 in February 1986, adopting its own far-reaching changes to pension law as amendments on April 16. Frustrated by the process of amending the House version of H.R. 3838, the committee decided in May to begin again with a more radical tax reform package. However, most of the previously agreed to employee benefit provisions remained unchanged in the new package that was adopted by the committee on May 29, and passed by the Senate on June 24. The Conference Report on H.R. 3838 was approved by the Senate on September 27, and the Tax Reform Act of 1986 was signed into law on October 22, 1986.

Title XI of the Tax Reform Act of 1986 makes major changes in pension and deferred compensation plans. The stated purpose of these pension proposals is to establish uniform pension rules; improve benefits for mobile, short-service, and lower-paid workers; restrict tax benefits to plans providing income in retirement; and limit accumulations and prevent the discriminatory use of tax-favored retirement plans by the highly-paid. The major changes in the tax treatment of pension and capital accumulation plans fall into four general areas: (1) limitations on tax-favored voluntary savings, (2) reform of coverage, vesting, and nondiscrimination rules, (3) changes in the rules governing distribution of benefits, and (4) modifications in limits on the maximum amount of benefits and contributions in tax-favored plans.

(1) Limitations on Tax-Favored Voluntary Savings

The Tax Reform Act tightens the limits on voluntary tax-favored savings plan in an effort to target limited tax resources where they can be most effective in producing retirement benefits. The Act repeals the deductibility of contributions to an Individual Retirement Account [IRA] for participants in pension plans with adjusted gross incomes [AGI's] in excess of $35,000 (individual) or $50,000 (joint)—with a phased-out reduction in the amount deductible for those with AGI's within $10,000 below these levels. It also reduces the dollar limit on the amount employees can elect to contribute through salary reduction to an employer plan from $30,000 to $7,000 per year for private-sector 401(k) plans, and to $9,500 per year for public sector and nonprofit 403(b) plans. Additionally, the act tightens the non-discrimination test that further limits the elective contributions of highly compensated employees in relation to the actual contributions of lower-paid employees. Finally, the act encourages small employer adption of pension plans by permitting employers with fewer than 25 employees to adopt simplified employer pensions [SEP's] with elective employee deferrals.

(2) Coverage, Vesting, and Integration Rules

To broaden the coverage of workers under pension plans, improve the benefits earned by mobile, short-service, and low-wage workers, and eliminate a perceived potential for abuse, the Tax Reform Act makes several changes in current nondiscrimination rules governing tax-qualified pension plans.

(a) Coverage

The Tax Reform Act increased the minimum requirements for the proportion of an employer's work force that must be covered under company pension plans. Under prior law, a plan (or several comparable plans provided by the same employer) had to meet either a "percentage test" or a "classification test" to be qualified for deferral of Federal income taxes. Employers who were unwilling to meet the straightforward percentage test found substantial latitude under the classification test to exclude large percentages of lower-paid workers from participating in the pension plan. Under the percentage test, the plan(s) had to benefit 70 percent of the workers meeting minimum age and service requirements (56 percent of the workers if the plan made participation contingent upon employee contributions). A plan could avoid having to meet this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. Classifications actually approved by the Internal Revenue Service, however, permitted employers to structure plans benefiting almost exclusively highly compensated employees.

Pension coverage was expanded in the Tax Reform Act by raising the percentage of employees that must be covered under the percentage test, and by eliminating the classification test and replacing it much tougher and more specific alternative tests: a "ratio test" and an "average benefit test." Under the new percentage test, 70 percent of "nonhighly-compensated" workers must benefit (as opposed to 70 percent of all workers). Alternatively, an employer can benefit a smaller percentage of the company's workforce if the number of nonhighly compensated workers benefiting is at least 70 percent of the number of highly-compensated workers. The "average benefit test" permits employers to adjust the coverage requirements to take into account the level of benefits in the plan. Employers can meet this test by providing non-highly-compensated employees, on average, at least 70 percent of the average benefit of highly compensated employees (counting noncovered employees as having zero benefits). Plans are required to meet these new coverage requirements by January 1, 1989.

(b) Vesting

Vesting rules in a pension plan govern the number of years of continuous service and participant has to have with the employer before they earn the right to receive a benefit. Under prior law, retirement plans were required to vest participants at least as rapidly as one of three alternative schedules. If no part of the benefit vested before 10 years, then benefits had to be fully vested in 10 years. Alternatively, employers could vest 25 percent of the benefit after 5 years, gradually increasing the percentage until 100 percent was vested in 15 years. The third schedule provided for a combination of age and length of service.

The Tax Reform Act requires more rapid vesting than in the past under one of two alternative vesting schedules. If no part of the benefit is vested before 5 years of service, then benefits have to be fully vested at the end of 5 years. If a plan provides for vesting of 20 percent of the benefit after 3 years, then the benefit must be fully vested at the end of 7 years of service. The new vesting schedule applies to all employees working as of January 1, 1989.

(c) Integration

Under prior law, plans could adjust the pension benefits they provided to take into account actual or anticipated Social Security benefits without being considered discriminatory. Internal Revenue Service rulings permitted a defined contribution plan to provide contributions on pay above the Social Security wage base ($42,000 in 1986) at a rate 5.7 percent higher than those provided on pay below the wage base. Plans could provide no contributions on pay below the wage base if the contribution rate above the wage base was 5.7 percent or lower. The rulings permitted a defined benefit plan to meet either an excess plan or an offset plan rule. In the excess plan, the difference in benefits as a percentage of final pay paid above and below the average Social Security wage base could not exceed 37.5 percent. In the offset plan, the final pension benefit could be reduced by an amount equal to 83.3 percent of the Social Security benefit. In practice, pension benefits were often eliminated for workers with low wages.

The Tax Reform Act modified the amount of integration permissable under the revenue rulings to prevent the elimination of pension benefits. The basic concept of the new integration rules is that participants receive, at a minimum, 50 percent of the pension benefit they would receive without integration. Defined contribution plans cannot contribute above the wage base at a rate more than twice the rate they contribute below the wage base, and in no case can have a differential greater than that under prior law (5.7 percent). Excess plans cannot pay benefits on final pay above the wage base at a rate exceeding twice the rate they pay below the wage base, and in no case can have a differential in the rate exceeding three-fourths of 1 percent times years of service. Offset plans cannot pay less than 50 percent of the pension benefit that would have been paid without integration, and in no case can reduce the pension by more than three-fourth of 1 percent of the participant's final average pay times years of service. The new integration rules apply to contributions or benefits after January 1, 1989.

(3) Distribution Rules

How and when a plan distributes benefits to employees has come to be recognized as a key factor in that plan's ability to deliver adequate benefits in retirement. Traditionally, different types of plans have distributed their benefits in different forms. Defined benefit pension plans (plans that specify the benefits) have generally provided distributions only in the form of an annuity at retirement, while defined-contribution pension, profit-sharing, or thrift plans (plans that specify the amount contributed) have generally provided distributions as a lump-sum payment whenever the employee leaves the company. Current tax law provides special tax treatment for lump-sum distributions—both under the IRA rollover rules if they are saved in a retirement account and under the 10-year forward averaging and capital gains rules without regard to how they are used.

Current policy regarding distributions is often criticized for encouraging the consumption of pre-retirement distributions and the loss of retirement savings. While not all employer plans are designed solely to provide retirement income, many of those that are provide lump-sum distributions for many circumstances other than retirement.

The Tax Reform Act establishes substantial disincentives to use pension or deferred compensation plan accruals for any purpose other than providing a stream of retirement income. The bill would impose an excise tax of 10 percent on distributions from a qualified plan before age 59½, other than those: taken as a life annuity, taken upon the death of the employee, taken upon early retirement at or after age 55, or used to pay medical expenses. Additionally, the bill would repeal the special tax treatment for lump-sum distributions now permitted under the 10-year-forward-averaging and capital gains rules. Finally, the bill would modify the tax treatment of distributions from plans with after-tax employee contributions. Under prior law, previously taxed employee contributions could be recovered tax-free from a pension or deferred compensation plan before taxes are applied to any remaining amount. The Tax Reform Act repealed the provisions that permitted an initial recovery or previously taxed contributions, and requires that taxes be paid on a pro-rata share of the total benefit not attributable to previously taxed contributions.

(4) Limitations on Benefits and Contributions

The amount of additional accumulation an individual can have each year in a tax-favored plan is limited under section 415 of the Internal Revenue Code. Under prior law, the annual benefit payable from a defined benefit plan could not exceed 100 percent of an individual's compensation (up to a maximum benefit of $90,000). The annual contribution made to a defined-contribution plan could not exceed 25 percent of compensation (up to a maximum of $30,000). If an employee participates in both defined-benefit and defined-contribution plans, their total accumulation is subject to a combined limit. Although the dollar limits are currently frozen, beginning in 1988 they will be indexed for post-1986 cost-of-living increases.

In recent years, the Congress has reduced and frozen the section 415 limits largely in an effort to raise revenue for the Federal Government in the context of deficit reduction. The Tax Reform Act restores the indexing of the section 415 limits, modifies the relationship between the benefit and contribution amounts to establish parity, and changes the adjustment in the defined-benefit dollar limit for early retirement. The defined-benefit limit would be indexed for inflation beginning in 1987, while the defined-contribution limit would remain frozen until the defined-benefit limit is four times as great—a ratio of contributions to benefits that is belived to result in roughly equal retirement benefits. Once the 4-to-1 ratio is reached, both limits would be indexed. Although the defined benefit limit remains the same for benefits commencing at age 65, the Tax Reform Act requires full actuarial reduction for benefits paid at earlier ages—so that the maximum annual benefit for someone retiring at age 55 is reduced from the current floor of $75,000 to $40,000.

To reduce the potential for an individual to over-accumulate by using several plans, the Tax Reform Act both retains the current law combined limit and adds a 15-percent excise tax to recapture the tax benefits of annual benefits (including IRA withdrawals) in excess of 125 percent of the defined benefit limit (but not less than $150,000).

One of the major purposes of the retirement provisions of the Tax Reform Act of 1986 is to expand the proportion of the population receiving pension benefits and raise average benefits from employer-sponsored plans. Data prepared by ICF, Inc., for the American Association of Retired Persons [AARP] indicates that the combination of expanded coverage, 5-year vesting, limits on pension integration and tighter distribution rules is expected to substantially increase future benefits paid to today's younger workers. The study simulated the pension income received by the families of workers who will reach age 67 in the years 2011-2020. The benefit improvements in the Tax Reform Act will raise average annual family pension income from $8,400 (under prior law) to $10,200 (1986 dollars) and will increase the percentage of families receiving pension income from 68 percent (under prior law) to 77 percent of families. Women, in particular, are expected to benefit from the pension reforms. ICF estimated that the Tax Reform Act changes will increase the number of women with pension benefits during the 2011-2020 period by 23 percent.

(B) PENSION ACCRUAL AMENDMENTS

Congress took an additional step to improve pension benefits after completing work on the Tax Reform Act by focusing at the end of 1986 on coverage and benefit accruals for older workers. The original legislation to require that employers continue to accrue benefits for older workers was introduced by Senator Grassley as S. 1427 in 1985, and was the subject of hearings before the Senate Committee on Labor and Human Resources Subcommittee on Aging on October 17, 1985. Nearly 1 year later—on September 17, 1986—the bill was added as an amendment on the Senate floor to the Omnibus Budget Reconciliation Act of 1986. The provision was broadened in the House-Senate Conference to include a requirement that workers within 5 years of the normal retirement age be covered under the employer's pension. The final version of the amendment was passed as part of budget reconciliation on October 17, and signed by the President as Public Law 99-509 on October 21.

The older worker pension amendments are intended to end age discrimination in the provision of pension benefits by making changes in both the ERISA coverage rules and benefit accrual requirements. Under prior law, employers were permitted to exclude from coverage under a pension plan any worker hired within 5 years of the normal retirement age of the plan. If the plan's normal retirement age was 65, workers hired after age 60 did not have to be included in the plan. Since all plan participants fully vest at the normal retirement age, this provision was intended to protect employers from having to vest workers within 1 or 2 years of employment. Under the new law, employers will be required to cover workers hired before the normal retirement age, but can delay vesting under the plan for 5 years from the date of employment. Thus, employers who hire a 63-year-old worker, for example, will have to include the worker in the pension plan, but will only have to pay benefits if the worker continues to work until age 68.

The new law also establishes that plans have to accrue pension benefits for workers who have not yet earned full benefits under the plan and continue to work after the normal retirement age. Previously, ERISA had permitted employers to suspend employee's benefit accruals at the normal retirement age, even though they had not yet earned the maximum benfit. However, it was unclear whether the Age Discrimination in Employment Amendments of 1978 that raised the mandatory retirement age from 65 to 70 had required that benefits continue to accrue. The new law resolves this uncertainty. Both provisions of the new law apply to service after January 1, 1988.

(C) SINGLE-EMPLOYER PENSION PLAN AMENDMENT ACT OF 1985

After year of deliberation over reform of the PBGC's single-employer termination insurance program, the Congress finally completed work in early 1986 on legislation reforming the program. By the end of 1985, conferees from the House and Senate had met and agreed on a single bill increasing the premium for single-employer termination insurance from $2.60 to $8.50 per participant, and restructuring employer liabilities to the PBGC in the event of termination of underfunded pension plan. However, the single-employer legislation was part of the Comprehensive Omnibus Budget Reconciliation Act of 1985 [COBRA] which was not finally acted upon before the end of the first session, and remained to be finally approved by the Congress on March 20, and signed by the President as Public Law 99-272 on April 7, 1986.

Although similar legislation had been introduced in several previous Congresses, the premium increase and reform effort gained momentum in the 99th Congress largely through its association with dificit reduction and the budget reconciliation legislation. The taxwriting committees and labor committees in both chambers reported out provisions which went to conference as three separate bills: H.R. 3500—one of the House reconciliation bills containing the provisions of H.R. 2811 as reported by the Education and Labor Committee in September; H.R. 3128—the other House reconciliation bill reported by the Ways and Means Committee in October; and S. 1730—the Senate reconciliation bill containing the premium increase reported by the Finance Committee and the reform provisions reported by the Labor and Human Resources Committee. Of the three, H.R. 3500 contained the most carefully worked out reform bill, and the only one that had been the subject of hearings.

The single-employer termination insurance bill, as finally enacted, raised the premium paid by employers from $2.60 to $8.50 per participant, and in return, tightened up considerably on the circumstances under which employers could terminate underfunded pension plans with limited liability to the PBGC. The act distinguishes between "standard" terminations, where the employer is not in financial distress, and "distress" terminations where the employer is unlikely to have the assets to meet their obligations under the plan. In a standard termination, employers will have to pay all benefit commitments under the plan, including benefits in excess of the amounts guaranteed by the PBGC that were vested prior to termination of the plan. In a distress termination—where a company filed for bankruptcy, or would clearly go out of business unless the plan was terminated, or where the cost of the pension had become unreasonably burdensome—employers will be liable to the PBGC only up to 75 percent of the underfunding in the plan. In addition, employers in a distress termination, will be liable for a portion of the amount of vested benefits in excess of the PBGC's guarantees: generally 75 percent of the amount owed, but not more than 15 percent of the plan's total benefit commitments. Employers will pay only 50 percent of the amount owed to either the PBGC or participants in years with no profits. In corporate transactions intended to avoid liability for an underfunded pension—within 5 years of termination—the company's controlled group at the time of the termination will remain liable.

The bill will substantially improve the funding of the PBGC and will increase the PBGC's claim on company assets and prevent some of the "dumping" of unfunded liabilities on the PBGC. By itself, however, the Single-Employer Pension Plan Amendments

Act does not solve the PBGC's financing problems, which grew substantially worse with the termination of the pension plans of the bankrupt LTV Corp. at the end of 1986 and beginning of 1987.

(D) LEGISLATION AFFECTING REVERSIONS OF PENSION ASSETS

The Department of Labor began in 1986 to develop an administration position on the termination of overfunded pension plans for the purpose of reclaiming surplus assets. The Department's ERISA Advisory Council appointed and received a final report from a task force on asset reversions, which the Department used as the basis for preparing recommendations expected to be provided in 1987 to the Congress on a broad range, of pension funding issues. In additional legislative activity, an amendment was incorporated in the Consolidated Omnibus Budget Reconciliation Act [COBRA] that delays the processing of asset reversion cases pending or filed before March 1, 1986. Finally, the Tax Reform Act of 1986, signed into law on October 22, 1986, contained a 10-percent excise tax on plan reversions.

In response to a requirement contained in COBRA that the Secretary of Labor complete a study of plan asset reversions by February 1986, the Department convened a task force of the Advisory Council on ERISA to review the reversion issue and comment upon its effects on pension plan beneficiaries and recommend statutory changes. In its report, released by the Department on May 21, the task force recommended a program for allowing plan sponsors to withdraw excess assets from ongoing plans. The intent of the task force was to make the withdrawal of assets and continuation of the plan a more attractive option to employers than termination of the plan. The task force program would permit employers to withdraw from on-going plans any assets in excess of 120 percent of the liabilities the plan would have to meet if it were terminated. Reversions from terminated plans would be subject to a tax surcharge that would not be levied on withdrawals from on-going plans. Withdrawals would be treated as experience losses to the plans and could be amortized over 10 years, with a limit on time before a subsequent withdrawal could be made of from 5 to 15 years. In addition, the task force called for modification, but not elimination, of the administration's asset reversion guidelines, issued in May 1984, that permit employers to terminate plans to recapture surplus assets with the creation of identical successor plans.

An additional approach to discouraging the termination of pension plans to recapture surplus assets is to place an excise tax on the reversion to recapture the tax advantages the employer had realized in building up the trust tax free. The Treasury Department recommended in their November 1984 proposal to the President on tax reform that the Congress levy a 10 percent excise tax on reversions. The Tax Reform Act (Public Law 99-514), signed into law on October 22, 1986, imposes a 10 percent tax on any plan asset reversions from plans terminating after December 31, 1985. The combination of lower interest rates and the threatened excise tax caused a subtantial decline in the number of pension plans with surplus assets filing for termination by the end of 1986.

4. PROGNOSIS

Most of the pension issues that have commanded attention in recent years were resolved in 1986. The sheer volume of pension reform legislation enacted this year has dampened the enthusiasm of the Congress in considering any additional pension legislation in the near future.

Pension funding issues are the single set of exceptions to this rule, however. This problem of the termination of pension plans with substantial unfunded liabilities, and the deteriorating financial condition of the Pension Benefit Guaranty Corporation has grown much worse during 1986 and the beginning of 1987. At the end of fiscal year 1985, the PBGC has an unfunded long-term liability of $1.3 billion. With entry of the LTV Corp. into chapter 11 bankruptcy in July 1986, and the subsequent termination of LTV's four steel industry pension plans at the end of 1986 and beginning of 1987, the PBGC assumed an additional $3 billion in unfunded liability, raising the total PBGC deficit to more than $4 billion. The worsening financial condition of the single-employer insurance program makes the passage of reform and financing legislation even more important than ever before. The administration has included a PBGC premium increase in their fiscal year 1988 budget submission, and is separately considering recommendations to the Congress to reform ERISA's minimum funding standards and provide a mechanism for withdrawal of surplus pension assets. Sometime during 1987, the Congress will have to consider passing either stopgap financing for the PBGC or a comprehensive bill reforming the funding requirements for private pension plans.

In addition, the Congress may begin to take a serious look in 1987 at the prospects for expanded pension coverage among small employers. Currently the major gap in pension coverage is the lack of pension plans among small employers. Although incentives to encourage small employers to adopt plans were included in the Tax Reform Act of 1986, they may not outweigh the disincentives to plan adoption in this and pervious legislation. A series of pension reform bills enacted over the last 5 years have imposed increasing administrative burden and cost on small employers who provided pension plans. The Tax Reform Act both increased the administrative requirements and benefits costs for small employers and reduced the tax benefits by lowering the personal tax rates. The question of how to encourage small employers to adopt pension plans will be one of increasing concern to the Congress in the coming years.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. BACKGROUND

State and local government pension plans cover 11.4 million active and 3.1 million retired participants in more than 6,600 plans. At the end of 1985, State and local pension plans had assets of $432 billion and were playing out $22 billion in benefits annually. Over 80 percent of these plans have fewer than 100 active members, but the largest 6 percent of plans cover about 95 percent of active membership. Nearly three-quarters of the State and local plans provide coverage under Social Security. Most do not integrate Social Security and pension benefits.

State and local pension plans were intentionally left outside the scope of Federal regulation under ERISA in 1974, even though there was concern at the time about large unfunded liabilities and the need for greater protection for participant. Although unions representing State and muncipal employees have from the beginning supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups have thus far successfully counteracted these efforts arguing that the extension of such standards would be an unwarranted—and unconstitutional—interference with the right of State and local governments to set the terms and conditions of employment for their workers.

2. ISSUES

(A) FEDERAL REGULATION

The issue of Federal regulation of public pension plans has changed little in the past 10 years. At that time, Government retirement plans were exempted from the major provisions of ERISA to allow more time to determine whether Federal minimum standards were needed. In addition, States had argued that the Federal Government did not have the constitutional grounds to regulate the State employee benefit plans. To resolve these questions, ERISA called for a joint task force of several congressional committees to review the status of public employee retirement systems and report to the Congress on their funding, financial disclosure, and benefit adequacy.

The Pension Task Force on Public Employee Retirement Systems, in its report to the Congress in March 1978, concluded that State and local plans were often deficient in respect to funding, disclosure, and benefit adequacy. The Task Force reported that Government retirement plans at all levels, but particularly small plans, were frequently not operated in accordance with generally accepted financial and accounting procedures applicable to private plans and other financial enterprises. There was a general lack of consistent standards of conduct, open opportunities for conflict-in-interest transactions, and frequent poor plan investment performance. Because many plans were not funded on the basis of sound actuarial principles and assumptions, potentially inadequate yearly contributions to fund future benefits put many participants at risk of losing benefits altogether. Lack of standardized and effective disclosure created a significant potential for abuse due to the lack of independent and external reviews of plan operations. Finally, although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans—covering 20 percent of plan participants—did not meet ERISA's minimum vesting standard.

There is considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. Recent studies suggest that the growth rate of public funds is outstripping the growth rate of private plans as public fund administrators move aggressively to fund unfunded liabilities. The sheer size of the investment funds suggests that a dependable Federal standard would be prudent.

The need for improved standards has not obscured the latent constitutional question posed by Federal regulation, however. In *National League of Cities* v. *Usery,*[1] the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. The Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority*[2] overruling *National League of Cities* has largely resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pensions in respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be cleared by the "fresh air" of disclosure.

A definitive statement on financial disclosure standards for public plans was issued in November 1986 by the recently formed Government Accounting Standards Board [GASB]. Statement No. 5 on "Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers" established standards for disclosure of pension information by public employers and public employee retirement systems [PERS] in notes to financial statements and in required supplementary information. The disclosures are intended to provide information needed to assess the funding status of a PERS, the progress made in accumulating sufficient assets to pay benefits, and the extent to which the employer is making actuarially determined contributions. In addition, the statement requires the computation and disclosure of a standardized measure of the pension benefit obligation. The statement further suggests that 10-year trend information on assets, unfunded obligations, and revenues be presented as supplementary information.

(B) SOCIAL INVESTMENT: SOUTH AFRICA DIVESTMENT

State and local pension plans are exceedingly vulnerable to local politics. At issue, this year as last, was the continued investment of pension assets in companies which do business in South Africa. About half of the Fortune 500 companies that are favorite blue chip investments for public and private plans fit this description. Action taken by State and local governments has ranged from full divestment of holdings in South Africa related banks or companies, to divestment of holdings only in companies which do not strongly adhere to the so-called "Sullivan principles," or to "no new investment" policies. Some estimates have put total American investment in South Africa as high as $14 billion.

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[1] 426 U.S. 833 (1979).

[2] 83 L. Ed. 2d 1016, 53 U.S.L.W. 4135 (1985).

Generally speaking, pension trusts are subject to a prudent investment standard. Plan managers have an obligation to seek the best possible combination of risk and return, maximizing income for the sole benefit of trust beneficiaries. The issue is whether it is possible to meet this obligation while excluding many high-yield stocks from the pool of potential investments. A further complication which arises in the case of State and local plans. Here the fund is an instrumentality of the State or local government, and must be responsive to the citizens' desire to pursue particular social policy goals.

The passage of local initiatives to ban investment in South Africa raise serious questions in terms of the balancing of the fund's obligations to its participants and to the public. There is a strong argument that it might be prudent to divest South African holdings before its economy deteriorates and would be sellers have no buyers. Yet, if a pension fund is forced to liquidate its portfolio at an inopportune time it could cost taxpayers millions of dollars in lost asset earnings. These shortfalls would have to be made up from general revenues.

3. LEGISLATION

(A) REPORTING AND DISCLOSURE: PEPPRA

As in the 98th Congress, the Public Employee Pension and Accountability Act [PEPPRA] was introduced in the House of Representatives, and in two bills on the same day; H.R. 3126, introduced by Representative Clay, and H.R. 3127, introduced by Representative Roukema. H.R. 3127 contains the same provisions as found in H.R. 3126, but includes an additional title amending the Internal Revenue Code to exempt State and local plans from certain present code requirements. Neither bill has progressed past subcommittee consideration. Essentially the same legislation has been before the Congress since 1982.

PEPPRA would require disclosure and reporting of financial and other information to participants and their representative organizations, Government officials, taxpayers, and the general public. It establishes fiduciary standards for plan managers and trustees and provides appropriate civil remedies, sanctions, and access to Federal courts to participants and beneficiaries. H.R. 3127 would, in addition, clarify the application of the Internal Revenue Code to public plans and extend the tax benefits of qualified plan status to such plans and to their participants.

The reporting and disclosure provisions would require that participants be furnished a summary plan description written in a manner calculated to be understood by the average plan participant. The administrator of each public employee pension benefit plan would also be required to publish and made available an annual report providing financial data and information on the plan's funding policy. The financial statements would have to be audited by an independent qualified public accountant, and an actuarial valuation would have to be made at least once every 3 years. The Federal reporting and disclosure requirements would not apply in States where the Governor certifies that the law of the State sets substantially equal requirements.

Pension plan fiduciaries who exercise authority or control over the administration, management, or investment of plan assets would be required to carry out their functions solely in the interests of the participants and beneficiaries. Fiduciaries would be personally liable for any losses associated with a breach of fiduciary duty. They would be required to be bonded, follow a "prudent person rule," and diversify investments to minimize the risk of large losses. A fiduciary could not deal with plan assets for his own account or engage in certain transactions with a "party in interest" unless for "adequate consideration." However, the Secretary of Labor may grant an exception upon a finding that the party-in-interest transaction is administratively feasible and the interests of plan participants are protected.

The Secretary of Labor and the attorney general of a State would have investigative authority to determine whether any person has violated the law. An Advisory Council on Governmental Plans would be established, although with limited powers and resources, to monitor the implementation of the law and to submit a report of its findings and recommendations to the President and Congress.

(B) DISINVESTMENT

On the local level, the movement for divestment of funds from corporations doing busines in South Africa continued in 1986 partly in response to increasing congressional and public concern about South Africa's apartheid policies. By October of 1986, a total of 15 States had moved to disinvest their pension plans to some extent, and an additional 4 had passed "no new investment" laws. Forty-six cities and 6 county governments have also implemented disinvestment legislation, and 2 other cities have "no new investment" acts. Advocates of divestment claim that restrictions now apply to State holdings worth more than $3.8 billion.

(C) TAX REFORM ACT OF 1986 (PUBLIC LAW 99-514)

Title XI of the Tax Reform Act of 1986, signed into law on October 22, 1986, makes significant changes in pension law aimed at improving future retirement income from traditional pension plans, particiularly for low-paid and mobile workers, and at reducting the potential for discrimination in the provision of employee benefits. As part of the overall tax reform goal of simplifying the tax code, many of the retirement provisions attempt to establish parity and uniform treatment among various types of pension and savings plans.

Public employee retirement plans are directly affected by some provisions of the Tax Reform Act that are specific to public plans, and are affected as well by provisions that apply generally to all plans. The act made two sets of changes that apply specifically to public plans: The maximum employee elective contributions to voluntary savings plans (401(k), 403(b), 457 plans) were substantially reduced, and the once-favorable tax treatment of distributions from contributory pension plans was eliminated.

Elective deferrals.—The Tax Reform Act sets lower limits for employee elective deferrals to savings vehicles, coordinates the limits for contributions to multiple plans, and prevents State and local governments from establishing new 401(k) plans. The maximum contribution permitted to an existing 401(k) plan is reduced from $30,000 to $7,000 a year, and the nondiscrimination rule that limits the average contribution of highly compensated employees to a ratio of the average contribution of nonhighly compensated employees is tightened. The maximum contribution to a 403(b) plan (tax sheltered annuity for public school employees) is reduced to $9,500 a year and employer contributions are made subject, for the first time, to nondiscrimination rules, and pre-retirement withdrawals are restricted unless they are needed for a hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remains at $7,500, but is coordinated with contributions to a 401(k) or 403(b) plans, and 457 plans are required to commence distributions under uniform rules that apply to all pension plans. The lower limits are effective for deferrals made on or after January 1, 1987; while the other changes are generally effective beginning January 1, 1989.

Taxation of distributions.—The tax treatment of distributions from public employee pension plans was also modified by Tax Reform Act to develop consistent treatment between employees in contributory and noncontributory pension plans. Under prior law, public employees who had made after-tax contributions to their pension plans could receive their own contributions first (tax-free) after the annuity starting date if the entire contribution could be recovered within 3 years, and then pay taxes on the full amount of the annuity after that point. Alternatively, employees could receive annuities in which the portions on nontaxable contributions and taxable pension were fixed over time. The Tax Reform Act repealed the 3-year basis recovery rule that permitted tax-free portions of the retirement annuity to be paid first—effective July 1, 1986. Under the new law, retirees from public plans must receive annuities that are a combination of taxable and nontaxable amounts.

The tax treatment of pre-retirement distributions was changed for all retirment plans in an effort to discourage the use of retirement money for purposes other than retirement. A 10 percent penalty tax is applied under the new law to any plan distribution before age 59½ other than distributions: in the form of a life annuity, at early retirement at or after age 55, in the event of the death of the employee, or in the event of medical hardship. In addition, refunds of after-tax employee contributions, and payments from 457 plans are not subject to the 10 percent tax penalty. The new tax law also repealed the use of the advantageous 10-year forward averaging tax treatment for lump-sum distributions received prior to age 59½, and provides for a one-time only use of 5-year forward averaging after age 59½.

The act also makes a number of changes that apply to tax-qualified pension plans but do not apply directly to Government plans. These include a reduction in the vesting period from 10 years to 5 years, modifications in the rules for integration of pension and Social Seccurity benefits to require payment of at least half of a nonintegrated pension benefit, tighter pension coverage and nondiscrimination rules to encourage broader participation in pension plans by lower-paid employees.

4. PROGNOSIS

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation in the near future. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments have consistently opposed Federal action, increased pressures to improve investment performance coupled with the call for responsible "social" investment may lessen some of the opposition of State and local plan administrations to some degree of Federal regulation. The current legislation's exemption from disclosure requirements for States with "substantially equivalent" disclosure statutes could help to soften some of the opposition to Federal standards. However, it is unlikely that Federal standards for public employee plans will get much serious consideration by the Congress in the near future.

C. FEDERAL CIVIL SERVICE RETIREMENT

1. BACKGROUND

The Civil Service Retirement System [CSRS] is the staff retirement plan for more than 2.7 million Federal civilian employees, hired before January 1, 1984. In 1986, it paid benefits to 1.5 million retirees and 500,000 survivor annuitants. It is a management tool designed to attract and retain qualified personnel while providing a measure of financial security to employees who have completed their careers or are unable to perform their duties.

Participants contribute roughly 7 percent of their salary toward CSRS, which provides vested benefits after 5 years of service, equal to a percentage of the participant's high 3 years of pay. The percentage is determined by multiplying the retiree's years of service by a multiple of 1.5 percent for the first 5 years of service, 1.75 percent for the next 5 years, and 2 percent for all years of service thereafter. Participants are entitled to unreduced benefits at age 55, provided they have completed 30 years of service, and no later than age 62 so long as they have 5 years of service. Until 1986, benefits were fully indexed for increases in the Consumer Price Index (CPI).

The rapidly rising Federal deficit and concern over Federal personnel costs has led to a call for cuts in CSRS over the past decade, when rapid rises in the CPI drove up program costs. The 1986 cost-of-living adjustment was cancelled by the Balanced Budget and Emergency Deficit Control Act of 1985, the so-called "Gramm-Rudman-Hollings Act." Concern about the lack of portable benefits for mobile employees and the need for revenue in Social Security led to the inclusion of Federal employees hired on or after January 1, 1984 in Social Security as a result of the 1983 amendments. This created a need and an opportunity for the Congress to re-examine the overall structure of Federal employee compensation. Congressional committees charged with the task of designing a pension plan to supplement Social Security for new hires conducted a lengthy study process, and their efforts resulted in the new Federal

Employees Retirement System [FERS], signed into law June 6, 1986. This system will become effective January 1, 1987.

Other disparities in treatment were addressed in tax reform. As part of the effort to tax all income on a more equitable basis and eliminate special tax benefits, a special rule benefiting retirees from plans with employee contributions was repealed. In the past, Federal retirees were among the few taxpayers able to take advantage of the "Three Year Basis Recovery Rule." This tax window was repealed by the Tax Reform Act of 1986. Additionally, the tax treatment of pre-retirement withdrawals of employee contributions was brought in line with rules governing private-sector pension plans.

2. ISSUES

(A) COST

Substantial criticism has been directed at the cost of the CSRS program. Total payments from the CSRS trust fund have tripled, in current dollars over the last decade. At the same time, the proportion of this cost paid by the Government has increased from 65 percent in 1975 to an estimate in excess of 80 percent in 1986.

The total employer cost of the CSRS is 25 percent of payroll, 5 to 8 percent more than the cost of a typical private sector plan, even after taking employer contributions to Social Security into account. The design of the CSRS includes a number of features which are costly relative to private sector plans. First, the system encourages early retirement of participants by providing unreduced benefits as early as age 55. Second, benefits have been fully indexed for inflation. Because Federal employee wages are more than 20 percent below those of comparable private sector employees and have not kept up with inflation, these feature in combination have encouraged early retirement. Finally, the salary base for benefits is the average of the employee's high 3 years of compensation, a shorter averaging period than is prevalent in private sector plans.

Inflation adjustment of CSRS benefits can be very costly. Accordingly to a 1980 study, each 1 percent COLA increases long-term plan costs by 10 percent; as inflation increases, plan costs rise at ever-escalating rates. If inflation is 6 percent, a COLA will double the costs of CSRS over what it would be if none were paid. Private pension plans usually adjust pensions for the cost of living on an ad hoc basis, generally limited to 3 or 4 percent a year. The only fully indexed retirement benefit most private employees receive is Social Security. Likewise, full private pension and Social Security benefits are generally available only at age 65 and are actuarially reduced if taken at earlier ages.

(B) ADEQUACY

While CSRS provides greater benefits for full career workers than a typical private pension plan, it provides relatively poor benefits to many more mobile civil service employees who leave before retirement. The Office of Personnel Management [OPM] estimated that 62 percent of all Federal employees participating in CSRS will receive no benefits. In all, two-thirds of benefits paid go to one-fourth of Federal employees. Employees must work 5 years to become vested and must work 10 years before the benefit formula begins crediting at full rates. Those who leave after vesting may choose to withdraw their own contributions instead of qualifying for benefits, but they lose the value of the Government's share. On the other hand, participants who leave their contributions draw benefits tied to their salary at the time they left Federal service, which can be quite low.

In addition, Federal retirees are potentially disadvantaged relative to other retirees by their lack of coverage under Social Security. Until recently, Federal employees have not been covered under Social Security during their tenure with the Government. Thus, they do not benefit from the portability of Social Security, nor its proportionately higher replacement rates for lower income participants. CSRS provides benefits based strictly on rate of pay and years of service.

Enactment of Social Security coverage for new Federal employees in the Social Security Amendments of 1983 has led to a redesign of the Federal retirement system. Social Security coverage for Federal employees had long been proposed by pension experts as a way to improve their retirement income while simultaneously improving the financial condition of the Social Security trust funds. The fundamental goal of policymakers has been to craft a retirement system which will encourage the growth of the type of Federal civilian workforce which best serves the Government's needs.

There are essentially two schools of thought as to the desirable work force profile. Some argue that the American public is best served by a staff of experienced career employees. For these analysts the key issue in reform of the CSRS is to reduce the incentives to employees to retire as soon as they are eligible for benefits. Thus retaining features of the old system that encourage retention by providing better benefits to employees with long service records and modifying the old system to limit post-retirement COLA's and the immediate availability of unreduced benefits that encourage early retirement. A second group of critics argues that the Federal Government should attract more mobile workers from the private sector who do not plan on a full career of service in the Federal Government. In order to attract this type of worker, the Federal retirement system needs to provide the same benefits to both short and long service workers, and make it easier for departing workers to take their full benefits with them when they leave Federal employment.

(C) MAJOR DESIGN OPTIONS

The development of a retirement system for new Federal workers involved debates over the issues of system design and system cost. Given a desired system cost, numerous benefit structures can be designed to meet that cost. System cost is strictly a function of benefit generosity; the system design provides the structure through which those benefits are provided. Furthermore, within any benefit configuration, specific features can be designed so that the cost of any advantages could be spread over the entire participant population or could be structured as a trade-off: more of one benefit can be provided by scaling down the generosity of another, or a specific category of beneificiary can be made to bear the cost of special benefits received by that group.

One issue in the design of the new Federal pension plan was the extent of employee involvement in paying for the cost of the plan. Employees under CSRS, currently contribute between 7 and 8 percent of their salary to CSRS, equal to about one-fifth the cost of the system when valued using assumptions that take into consideration future wage growth and inflation. Most private sector employees, on the other hand, do not contribute to their pension system, but do make contributions of 7.15 percent of pay up to $43,800 (for 1987) to Social Security.

In addition, whether to retain full automatic COLA's in the defined-benefit component of the new Federal retirement system was an important question. Some analysts regard COLA protection as a bulwark against erosion of their benefits by inflation. However, this provision has in the past been one of the single most costly features of CSRS. Opponents of this provision argued that full inflation protection is rarely provided for pension benefits in the private sector, although it is provided in Social Security. Since new Federal retirees will receive indexed Social Security benefits, a strong case was made for partial COLA's or COLA's for only certain classes of retirees (e.g., the disabled or those over 65) on the pension benefits.

Another design issue centered on the coordination of Social Security benefits with the annuity provided by the Federal pension plan. Benefit adequacy is commonly measured in terms of the "replacement rate" provided by the annuity—that is, the ratio of the dollar value of retirement benefits to pre-retirement income. The President's Commission on Pension Policy estimated in 1981 that rates ranging between 51 to 86 percent would allow retirees to maintain their pre-retirement standard of living. CSRS provides benefits purely on the basis of final salary, age, and years of service. It therefore provides the same gross replacement rates for retirees with similar service records. In conjunction with a progressive income tax, CSRS effectively provides higher net replacement rates to retirees with higher final wages.

On the other hand, Social Security is a social insurance program. It provides benefits to the insured worker or his dependents when the worker's income is interrupted by death, disability, or retirement. The program implicitly assumes that these circumstances cause economic need. Social Security also assumes that low-income families need a higher replacement rate than do upper-income individuals, and Social Security benefits are substantially titled toward individuals with low career wages.

There were three basic options for the new Federal retirement plan to recognize the redistributive aspects of Social Security. The new system could completely ignore, completely offset, or partially offset benefits from the retirement system for receipt of Social Security benefits. Both the first and second options create significant problems in terms of the system's manpower goals. If the new Federal retirement system ignored the receipt of Social Security beneifts, then replacement rates for lower paid employees would be substantially higher than those for high paid employees. Such a reduction could discourage many experienced personnel from serving in the Federal Government, particularly since salaries for upper level civil service jobs are already perceived as being lower than wages for comparable positions in the private sector. The second option of a total offset for receipt of Social Security would result in similar benefits for employees under the new and under the old Federal retirement system, but would conflict with the intent of the new pension reforms in the Tax Reform Act of 1986 that would limit the reduction in pension benefits through integration with Social Security. In addition, since a greater proportion of the lower paid civil service employee's retirement benefit would come from a portable Social Security benefit. Some analysts have suggested that this benefit would increase turnover in the lower grades of the civil service.

The third option, a partial offset formula would best meet the goals of the present retirement system. It would preserve some of the advantages of Social Security's benefit tilt and portability to lower paid workers, and would at the same time keep total replacement rates somewhat similar to the current CSRS.

An addition of a voluntary savings vehicle to the Fedeal retirement system, similar to the thrift and 401(k) plans in the private sector, was seen as a way to ameliorate much of the impact of changes in the CSRS on higher-paid employees, while still providing higher benefits to lower paid employees. A Voluntary Capital Accumulation [VCA] plan allows an employee to voluntarily contribute additional money to the retirement system. The incentive for making these extra contributions is the deferred payment of income tax on the contributions until retirement, when the employee's tax burden is usually lower. Often employers provide the additional incentive of a matching contribution for each $1 contributed by the employee. Because lower paid employees generally have less money for discretionary savings, data from the private sector indicates that they will participate at lower rates than higher paid employees. This projected difference in participation rates account for the different effects that VCA's are likely to have on the total retirement income replacement rates for lower and higher paid employees.

(D) COST-OF-LIVING ADJUSTMENTS FOR CURRENT RETIREES

Civil Service Retirement COLA's were eliminated in fiscal year 1986 under the provisions of the Gramm-Rudman-Hollings Act. The act created two categories of programs which receive automatic COLA's; those for which COLA's would automatically be suspended in the event the Government failed to meet its deficit reduction targets, and those which would be exempt from cuts. The CSRS (as well as the military retirement plan) was not exempted, and Gramm-Rudman further called for an immediate suspension of the 3.1 percent COLA scheduled for both civilian and military retirees in January 1986. For an average civil service retiree receiving a monthly benefit of $1,119, this resulted in a loss of $34 per month. Although a portion of the Gramm-Rudman law was declared unconstitutional by the Supreme Court, Congress reaffirmed the cancellation of the 1986 COLA in July. The total savings in fiscal year

1986 to the Federal Government because of the cancellation of the COLA for civil service retirees was $540 million. Gramm-Rudman specifically forbids reduction of benefits other than COLA's under sequestration.

In addition to possible sequestration, civil service retirement COLA's faced possible reduction or elimination in fiscal years 1987 and beyond as part of congressional budgets designed to meet Gramm-Rudman-Hollings goals. With predictions of the fiscal year 1988 deficit at $50 billion or more over the target amount, civil service retirement COLA's are by no means guaranteed in the future.

(E) TAX TREATMENT OF BENEFITS

During the debate on tax reform legislation, a special tax provision for employees receiving annuities from contributory plans came under close scrutiny. Like many other public sector and relatively few private sector retirees, Federal retirees receive annuities from plans to which they have made employee contributions. The portion of the annuity attributable to the employee's contributions is not treated as taxable income in retirement because the original contributions were taxed when made.

Under old tax law, when a CSRS participant retired, they had the option of treating 100 percent of the pension received at the beginning of retirement as a return of after-tax contributions. Under this special rule, until the cumulative amount received equaled the employee's contributions, no income tax was due on the annuity payments. After the cumulative monthly checks equaled the employee's contributions, the remainder of the pension benefits were treated as the employer's contributions to the annuity and the full amount was subjected to income tax.

The average retiree received all of his or her contributions back in approximately 18 months, however, it could take considerably longer in some cases. If it would take longer than 3 years to recoup the employee's contributions, the tax law required the use of an alternative rule (the so-called "general rule") in which a fixed proportion of the monthly pension check, based on employer-paid contributions and earnings, was taxed from the beginning of the annuity.

As Congress and the President developed plans to make the tax code simpler and fairer, all existing provisions, including the 3-year basis recovery rule came under close scrunity. When repeal of the rule was proposed, its supporters objected on several grounds. First, they noted the hardship it would create for workers nearing retirement who had long-standing plans concerning financial decisions in the early years of retirement. Many who counted on a promise of tax-free pension checks at the beginning of retirement felt the 3-year rule was part of the bargain they had struck as long-time Government employees and resented attempts to eliminate this tax option, particularly for those nearing retirement.

Fears were also expressed that repeal of the rule would have an adverse impact on the Federal work force, as substantial numbers of eligible workers retired en mass, just before the implementation date in order to avoid being affected.

Many criticized the proposed repeal as a "gimmick" to increase short-term revenues, thereby temporarily reducing mounting Federal deficits. Repeal would raise revenues in two ways. First, individuals would pay income taxes on a substantial portion of their pension checks from the first month of retirement, whereas, under the 3-year rule, they did not pay taxes for up to 3 years. This revenue increase would be short-term, leveling out as the general rule was fully phased-in for all retirees. A second revenue source would result from higher marginal rates on income-generating events early in retirement such as the sale of assets, the withdrawal of tax-deferred savings, or income from alternative employment.

Finally, critics contended that it would complicate the processing of retirement applications. The 3-year rule was first introduced in 1954 for purposes of tax simplification, so that individuals actuarial determinations would not have to be made for large numbers of retirees. Supporters of the rule fear that repeal would greatly increase the time it takes to process applications and create backlogs and rising error rates.

Opponents of the 3-year rule advocated its repeal as part of the effort to improve fair and equal treatment in the tax system. They argued that the year or two of very low tax rates that the 3-year rule provides to some workers provides an unfair advantage only for certain people, permitting them to convert assets and receive other income at an artificially low tax rate.

Additionally, the 3-year rule's critics argued that the rule could be harmful to some retirees. They expressed a fear that some retirees are not prepared for the abrupt change in their disposable income when their contributions have been recouped, even though they are aware of the tax implications. There were also concerns raised about the taxation of full benefits after the recovery period. It was argued that many retirees would need greater disposable income at the end of retirement, when they were much more likely to have greater expenses, such as long-term care.

The 3-year rule remained an attractive target throughout the tax reform debate largely because of the estimated Federal revenue gains attributed to its repeal. The Joint Committee on Taxation estimated that, in the first 5 years after repeal, tax revenues would be increased by approximately $7.5 billion.

3. Legislative Action in 1986

(A) FEDERAL EMPLOYEES RETIREMENT SYSTEM (FERS)

As of January 1, 1984, new Federal workers, returning workers with a break in service of at least 1 year, the President, Members of Congress, Federal judges, and Executive Branch political appointees became subject to the tax and benefit provisions of Social Security. The addition of Social Security coverage to the existing Federal pension system would have duplicated some existing CSRS benefits, and raised combined employee contribution rates to more than 13 percent of pay. While congressional committees undertook the task of designing a new system for those employees now under Social Security, a 2-year interim arrangement was implemented to provide relief from the dual contributions and a temporary benefit structure.

The Senate passed a bill providing for a new retirement plan on November 7, 1985. The House Post Office and Civil Service Committee pased its own version on November 14, 1985. Stalled negotiations in a conference committee required the extension of the interim plan through April 30, 1986. Disagreements continued past the extension, and employees under the interim plan had both full CSRS and Social Security contributions withheld from their pay until the new system was signed into law June 6, 1986 (Public Law 99-335). Excess CSRS contributions were refunded soon after the law went into effect.

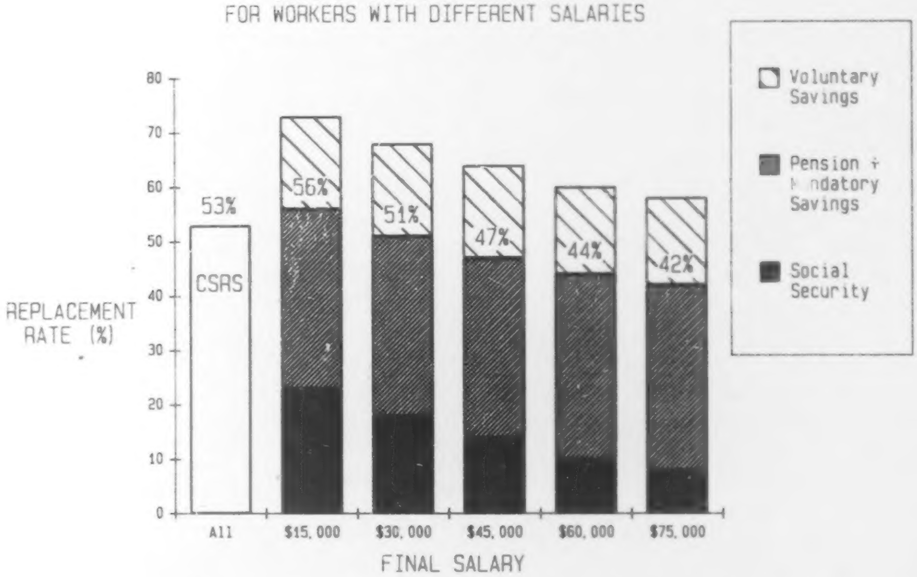
The inclusion of FERS participants in the Social Security program allowed the plan's drafters to provide Federal workers with two design elements which should help to build a strong Government work force: benefit portability and income replacement rates comparable to those found in the private sector.

Workers who will not make a lifetime career of Federal service, or who will come in and out of the Federal Government, will be able to accrue Federal retirement benefits that can be accumulated with benefit from other employment. In addition, Social Security contributions will help workers build work quarters as they move in and out of the public sector.

Benefits under CSRS provide replacement rates on the basis of years of service, not level of salary, whereas Social Security is "tilted" toward lower income workers by taking into account both eligible work quarters and salary levels. The chart below illustrates how the replacement rates for FERS will differ from CSRS, with the example of a 62-year-old worker retiring in the year 2030 after 30 years of Federal service. Adjusting to 1985 dollars, the gross replacement rate for this employee under CSRS would be 53 percent, regardless of the employee's salary level. Under FERS, however, the replacement rate will vary considerably with salary level. Assuming this employee made only voluntary contributions to the Thrift Savings Plan (see section 2 below), the replacement rate would be 56 percent at a $15,000 final salary level, but would fall to 42 percent at a $75,000 level. These differences are entirely attributable to the benefit structure of Social Security, as the pension portion of the retirement benefit is constant regardless of salary level.

CHART 2-5

BENEFIT VALUE AT RETIREMENT
FOR WORKERS WITH DIFFERENT SALARIES



NOTE: Assumes worker retiring in the year 2030 at age 62 with 30 years of service.

SOURCE: Congressional Research Service, Report No. 86-137 EPW

The CSRS costs the Federal Government 25 percent of its annual payroll. Features such as redesigned employee contributions will result in costs of 22.9 percent of payroll for FERS. CSRS requires a 7 percent contribution from an employee's salary. Participants in FERS will contribute a mandatory 7.1 percent, with additional voluntary contributions of up to 10 percent. (The Congressional Research Service estimates that voluntary contributions will average 2.8 percent of salary.)

Beginning January 1, 1987, FERS will automatically cover Federal civil servants hired after December 31, 1983, and Members of Congress first serving after that date who did not irrevocably elect out of the plan. Other Members and employees covered by the current CSRS will be permitted to join during an "open season," from July 1 to December 31, 1987. The decision to join is irrevocable. The system includes, in addition to Social Security, a basic defined benefit plan, and a supplemental capital accumulation plan called a "Thrift Savings Plan" (TSP).

(1) The Defined Benefit Plan

The FERS defined benefit was designed to reduce the cost pressures that have been realized in CSRS from its generous early retirement benefits. FERS is less generous to early retirees both in the base benefit paid and COLA increases than it is to those who delay retirement. The FERS defined benefit plan, similar to private sector plans in many respects, allows workers to earn 1 percent of the average of their highest 3 consecutive years of wages for each year of service completed. Workers retiring at age 62 or later with at least 20 years of service will receive an additional 0.1 percent of pay for each year of service. In contrast to CSRS, unused sick leave will not be creditable for purposes of computing retirement benefits.

In contrast to the CSRS, the FERS defined benefit is reduced for retirement before age 62. Unreduced benefits from the defined benefit plan will be payable at age 62 with 5 years of service; at age 60 with 20 years of service; and at the minimum retirement age with 30 years of service. "Minimum retirement age" [MRA] is 55 for workers who reach that age by the year 2002, and increases in six annual steps, reaching age 56 in 2009. Beginning in 2021, the MRA again rises by 2 months per year until the full retirement age (57) is reached in 2027. Reduced benefits are payable to retiring employees past the MRA with 10 years of service but insufficient service to be eligible for a full benefit. The reduction is 5 percent for each year under age 62. Workers who leave Federal service involuntarily at any age with at least 25 years of service, or after age 50 with at least 20 years of service, will be eligible for unreduced benefits.

Retirees with full benefits between the MRA and age 62 will be paid a supplement approximately equal to the amount of the estimated Social Security benefit based on Federal service payable to the retiree at age 62. This supplement will also be paid to involuntarily separated workers from ages 55 to 62. Supplemental payments will be subject to an earnings test similar to that in place for Social Security beneficiaries.

Deferred benefits will be payable at age 62 to workers who cease Federal work before retirement, provided they have at least 5 years of civil service, and have not withdrawn their contributions at separation. Deferred benefits are also payable without reduction to workers at the MRA with 30 years of service at separation or at age 60 with 20 years of service at separation. Reduced deferred benefits are also available at age 55 with at least 10 years of service. The reduction is 5 percent for each year under age 62.

Cost-of-living adjustments [COLA's] will be paid annually based on changes in prices as measured by the Consumer Price Index [CPI], except that regular retirees under age 62 will not receive any increase. The COLA will be equal to the CPI percentage increase, up to 2 percent. If the CPI increase exceeds 2 percent, the COLA will equal the greater of 2 percent, or the CPI change minus 1 percentage point.

(2) The Thrift Savings Plan [TSP]

FERS supplements the defined benefit plan with a contributory defined contribution plan that resembles the popular 401(k) plans used by many private employers. Employees accumulate assets in the TSP in the form of a savings account that can be furnished in either a lump sum or converted to an annuity when the employee retires. One percent of pay will be automatically contributed to the TSP by the employing agency. Employees will be permitted to contribute up to 10 percent of their salaries to the TSP, and the employing agency will match the first 3 percent of pay contributed on a dollar-for-dollar basis, and will match the next 2 percent of pay contributed at the rate of 50 cents per dollar. Thus, the maximum matching contribution to TSP by the Federal agency will equal 4 percent of pay, and the automatic contribution of the agency will add another 1 percent of pay. Therefore, employees contributing 5 percent or more of pay will receive the maximum agency match.

An open season will be held every 6 months to permit employees to change levels of contributions and direction of investments. Optional investment opportunities will be phased-in over a 10-year period, including special Government securities, fixed-income securities, or a stock portfolio. Employees will be allowed to borrow from their accumulated TSP beginning in 1988 for the purchase of a primary residence, educational or medical expenses, or financial hardship.

(3) Employee Contributions

Employees participating in FERS are required to contribute to Social Security. The tax rate for cash benefits is 5.7 percent of pay in 1986 (6.06 percent beginning in 1988 and 6.20 percent beginning in 1990) up to the maximum taxable wage level ($43,800 in 1987) that is indexed to the annual growth in wages of the economy at large. Employees also contribute 1.3 percent of all pay to the defined benefit plan through the end of 1987, 0.94 percent of pay in 1988 and 1989, and 0.8 percent of pay beginning in 1990.

At separation of service or retirement, employees will have the option of withdrawing their own contributions to FERS in an actuarially reduced lump-sum payment. For those not retiring, this choice becomes a relinquishment of the employer's contribution, thus, they will be ineligible for deferred pension benefits at retirement. When the lump-sum is taken at retirement, it actuarially reduces the monthly retirement annuity the retiree (and any surviving spouse) will receive.

(4) Disability Benefits

Employees would be eligible at any age for disability retirement after 18 months of creditable service if they are unable, because of disease or injury, to perform useful and efficient service in their current position or a vacant position at the same grade level for reassignment in the same agency and commuting area. Employees applying for disability benefits under FERS may also apply for disability benefits under the Social Security system. Benefits will be based on high 3 years of pay and offset to an extent by Social Security benefits.

(5) Survivor Benefits

The survivor benefit plan feature of FERS provides lump-sum payments to all surviving spouses of workers who die before retirement, plus, in some cases, annuities to such survivors. Survivors of retired workers are eligible for an annuity if the couple elects the survivor annuity plan. The survivor annuity plan may be waived only if the spouse provides written, notarized consent.

Children's survivor benefits under FERS are payable to surviving children until age 18, or until 21 if they are full-time students. Disabled children incapable of self-support may continue to receive benefits for life if the disability began prior to age 18. All children's benefits are offset by any Social Security benefits payable.

(B) FISCAL YEAR 1987 BUDGET

For fiscal year 1987, the Reagan Administration once again proposed changes in civil service retirement to reduce its costs and "conform Federal retirement policy more closely to the private sector." However, none of the administration's proposals for structural changes were enacted, in large part because of the introduction of the new FERS plan. The President's six major costcutting proposals were:

—Withhold the COLA due in 1987.
—Limit all future COLA's to the rate of increase in the Consumer Price Index (CPI) minus 2 percentage points.
—Reduce benefits paid to workers retiring before age 62 by 2 percent for each year less than age 62.
—Base the benefit on the highest 5 years of salary, rather than highest 3.
—Eliminate or restrict eligibility criteria for certain survivor benefits.
—Raise employee contributions to the CSRS trust funds from 7 percent to 9 percent in 1987.

The administration projected deficit reduction of $1.6 billion in fiscal year 1987, and a total of $15.6 billion over 5 years, if these measures were implemented.

Congressional action on the fiscal year 1987 budget made no changes in CSRS benefits or contributions and left CSRS COLA's intact. The House budget resolution (H. Con. Res. 337) assumed payment of the COLA "at the actual rate of inflation." Similar language was used in the Senate budget resolution (S. Con. Res. 120), which was eventually adopted by both Houses in late June. On October 23, the Commerce Department announced a rise in the Consumer Price Index of 1.3 percent from the 3d quarter of 1985 to the 3d quarter of 1986. This measure is used to determine COLA's for CSRS benefits as well as other Federal benefits, such as Social Security. The 1.3 percent increase will result in an average increase of $17 per month, bringing average monthly benefits for nondisability annuitants to $1,306.

(C) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

As an amendment to this year's budget reconciliation bill, the Senate approved language amending the Gramm-Rudman-Hollings law to protect civil service retirement benefits (and certain other Federal retirement and disability benefits) from further reductions under sequestration. This amendment passed the Senate by voice vote on September 19, 1986. Similar language had passed the House of Representatives as part of the freestanding bill, H.R. 6060, on June 24, 1986, by a vote of 396 to 19. The amendment language became part of the House and Senate conference agreement, adopted by both Houses and eventually signed into law by the President on October 21, 1986 (Public Law 99-509).

This law prevents further automatic cancellation of COLA's under sequestration, but is not a safeguard against any COLA reduction. Congress retains the power to reduce or eliminate CSRS benefits and COLA's as part of budgets designed to meet Gramm-Rudman targets through 1991.

(D) THE TAX REFORM ACT OF 1986

(1) Taxation of Pre-Retirement Distributions

The Tax Reform Act of 1986 (Public Law 99-514), changes the tax treatment of certain pre-retirement distributions of an employee's contributions at separation of service before retirement age. Workers who leave Government service before retirement are entitled to do one of two things with the pension benefits they have accrued. If benefits are vested, workers may leave all employer and employee contributions in CSRS (or FERS where applicable) and receive full benefits when they reach retirement age. Many, however, may not be vested or may not find the pension they would be entitled to adequate to their needs in retirement. These employees have the option of withdrawing their own contributions to their retirement plan and forfeiting the employer-paid portion of their benefits.

(2) Taxation of Retirement Annuities

The Tax Reform Act of 1986 (Public Law 99-514), changes the tax treatment of retirement benefits paid from CSRS by repealing the "3-year basis recovery rule" under which retirees paid no income taxes on their pension until their monthly pension payments equaled the previously taxed contributions they had paid into the system while working. Retirees who were unable to recoup all of their contributions within 3 years were subject to the "general rule," which taxed, from the beginning, that portion of the pension payments determined to be employer-paid. As a result of the repeal, Federal workers retiring after June 30, 1986, will be subject to the general rule and taxed on part of their pension from the start of retirement. Because the pension will be largely taxable income, other income received shortly after retirement may be taxed at a higher marginal rate than it would be if none of the pension were taxable, although these marginal rates under the new tax legislation are lower than under old tax law. On the other hand, a retiree's tax burden in the later years of retirement will be less than what it would have been under the 3-year rule because of the pro-rated tax over the lifetime of the annuity.

Additionally, it should be noted that the new tax law will subject annuity payments to full taxation at such time as the employee's contributions have been fully recouped. Because the tax calculations are based on life expectancies, some retirees will find their annuities subject to 100 percent taxation late in their retirement years.

(3) Taxation of Lump-Sum Payments at Retirement

The Tax Reform Act of 1986 will treat post-retirement lump-sum payments of employee contributions in the same manner as full annuity payments. That is, the value of the lump-sum payment and the remaining annuity amount would be added together and the proportionate shares of the employer's and employee's contributions would be assessed. This rate would then be applied to both the lump-sum and the monthly annuity payments.

The new law does place a penalty on the withdrawal of an employees' contributions in certain limited circumstances. The 10 percent penalty on early withdrawals from Individual Retirement Accounts [IRA's] except in cases of hardship is extended to early withdrawals from qualified pension plans. This penalty would affect (a) Federal workers under age 55 who retire under special early retirement provisions pertaining to job abolishment, agency reorganization, or reduction-in-force, and (b) air traffic controllers, Federal law enforcement officers and firefighters for whom normal retirement is age 50 with 20 years of service. Even though the new tax law redefines the sums withdrawn to be employer contributions, the withdrawal cannot be rolled over into an IRA or other qualified plan because it will not generally constitute 50 percent of the amount of the employee's lifetime annuity, and therefore, will not meet the IRS requirement for rollovers.

Although workers retiring on or after June 6, 1986, when the law authorizing FERS took effect, were legally entitled to elect this withdrawal, administrative confusion because of the effects of the tax reform law resulted in these elections being unavailable. None had been paid as of July 1, 1986, the date on which the new tax bill changed the tax treatment of these distributions. The Internal Revenue Service has informed the Office of Personnel Management that when the lump-sum withdrawal is eventually paid, it will be taxable if the former employee has begun to receive an annuity check before they receive the lump-sum withdrawal. Had the Office of Personnel Management made these withdrawal payments before July 1 and before the start of the retiree's annuity, they would have been covered under the old tax law and would not have been taxable.

4. Prognosis

The year 1986 saw major legislative action in both the structure of civil service retirement benefits and the tax treatment of benefits. Congress will probably make few changes in the structure of the new FERS in the foreseeable future. For CSRS participants, although Congress has demonstrated an intent to leave the system unchanged for those workers currently covered by it, some have expressed a fear that down the road, as FERS participants begin to outnumber CSRS participants, the voice of those dependent on CSRS for their retirement income will grow weak, and beneficiaries will be forced to bear a disproportionate share of budget-cutting efforts. Already CSRS retirees have experienced the loss of their 1986 COLA as Congress and the President search for ways of reducing mounting Federal deficits. It remains to be seen whether this task can be accomplished without further reduction of retirement benefits for civil servants.

The tax treatment of civil service benefits has been brought more closely in line with the treatment of private pension benefits under the Tax Reform Act of 1986. This sweeping tax overhaul legislation contains many controversial provisions and has yet to be fully tested. Although Congress certainly will continue to amend the tax code in the future, it is doubtful that the favorable tax treatment once accorded civil service retiree's lump-sum withdrawals of their own contributions to their pension will soon return.

D. MILITARY RETIREMENT

1. Background

Until 1986, the military retirement system remained virtually the same as it had been since its inception following World War II, due to a vocal and effective lobby of participants and those who administer the program. In 1986, 1.4 million persons received military retirement benefits, totaling $17.6 billion. Three types of benefits are provided under the system: standard retirement benefits, disability retirement benefits, and survivor benefits under the Survivor Benefit Program [SBP]. With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants. A participant's retirement benefit is based on a percentage of his high 3 years of basic pay, determined by multiplying years of service by a multiple of 2.5. In no case does a retiree receive more than 75 percent of basic pay in retirement and since no vesting occurs until after 20 years of service, a participant receives a minimum of 50 percent of their basic pay. The benefit is payable immediately upon retirement from military service, regardless of age and without taking into account other sources of income which the retiree may receive from other sources. By statute all benefits are fully indexed for changes in the Consumer Price Index [CPI], however, the 1986 cost-of-living adjustment was cancelled by the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings).

Those entering military service after August 1, 1986, will be covered by a retirement system with several different features. First, the pay computation base is "skewed" so as to favor longer serving military personel, by increasing the rate of retired pay computation base from 2 to 3.5 percent for each year of service after 20 years. Second, when a retiree reaches age 62, his or her retired pay will be recomputed on the basis of the old formula—a straight 2.5 percent. Third, cost-of-living adjustments [COLA's] will be held at 1 percentage point below [CPI] for this group of military personnel.

2. Issues

(A) COST

The military retirement system has been highlighted by numerous commissions and the media as one of the principal programs aggravating the Federal budget deficit. In this instance, escalating costs are compounded by the public perception that retirement from the military is synonymous with retirement to another job. Most participants are eligible and do retire in their early forties and fifties, with a benefit equal to half of their basic pay.

Approximately 1.5 million retired officers, enlisted personnel, and their beneficiaries received nearly $18.4 billion in annuity payments in 1986. At current rates of growth, this expenditure will reach an estimated $45 billion annually by the end of the century. In 1986 military retirees received an average of $12,671 in benefits.

In particular, four identifiable features of the military retirement system greatly contribute to its cost. First, full benefits begin immediately upon retirement—sometimes as early as age 38 or 40, and continue until the death of the participant. Second, military retirement benefits are fully indexed for inflation. Third, the system is basically noncontributory, although in order to provide survivor protection, the participant must make some contribution. Finally, military retirement benefits are not integrated with Social Security benefits.

Supporters of the current military retirement scheme have identified several characteristics arguably unique to military life which they feel justifies relatively more liberal benefits to military retirees than other Federal retirees. All retired personnel are subject to involuntary recall in the even of a national emergency; retirement pay is ostensibly part compensation for this exigency. Military service has been seen to place special demands on military personnel, including higher levels of stress and danger, and more frequent separation from family, than civilian service. Finally, the current benefit structure provides a significant incentive for older personnel to leave the service in order to maintain "youth and vigor" in the armed services. In this respect it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Only a small minority of the studies conducted in the past decade have recommended contributions by individuals. As a result, for employees no refund contributions are available to those separating service before the 20-year vesting period and the full cost of the program shows up as an agency expense in the budget unlike the civilian retirement system were one-fifth of cost is paid by employee contributions.

Finally, since the institution of Social Security coverage for military personnel in 1956, military retirement benefits have been paid wihout any offset for Social Security receipt. Taking into account the frequency with which military personnel in their middle forties retire after 20 years of service, it is not unusal to find them retiring from a second career with a pension from their private employment, along with their military retirement, and a full Social Security benefit. Lack of intergration of military retirement and Social Security benefits generally adds to the preception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, a feature which retirees have traditionally considered central to the adequacy of retirement benefits. In recent years full indexing of military and other Federal retirement benefits has become the object of most deficit reduction measures. Most recently, the 1986 COLA was cancelled under the provisions of the Gramm-Rudman-Hollings Act.

The act created two categories of programs which receive automatic COLA's; those for which COLA's would automatically be suspended in the event the Government failed to meet its deficit reduction targets, and those which would be exempt from cuts. The military retirement plan (as well as the Civil Service Retirement System) were placed in the first category for the purposes of future sequestration. However, Gramm-Rudman specifically forbids any reduction of military retirement benefits through sequestration.

In addition, the statute specifically suspended the 3.1 percent COLA scheduled for both military and civilian retirees in January of 1986. The cancellation of the military retirement COLA resulted in a saving of $410 million in fiscal year 1987. For an average military retiree receiving a monthly benefit of $1,055.92, this resulted in a loss of $24.29 per month. Although one aspect of the Gramm-Rudman law was declared unconstitutional by the Supreme Court, Congress reaffirmed the cancellation of the 1986 COLA with a joint resolution on July 17, 1986 (Public Law 99-366). Military retirement benefits themselves, as well as COLA's, could conceivably be reduced through specific legislation adopted as part of congressional budgets designed to meet Gramm-Rudman-Hollings deficit reduction targets.

(B) RETIREMENT ADEQUACY

The temptation to compare military pensions to those found in the private sector solely on the basis of economic factors is difficult to avoid, especially absent any immediate threat of war. The pivotal issue, in evaluating the military retirement system however, is not cost, but the system's ability to provide adequate retirement income to those men and women who serve in the Armed Forces. Several recent studies of the military retirement system have suggested that the 20-year service requirement is unfair to the majority of military personnel. Nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing the requisite 20 years of service. It has been suggested that this design is likely to prolong the careers of marginal military personnel beyond their usefulness, while simultaneously providing an incentive for highly skilled and experienced personnel to leave the Armed Forces for second careers as soon as they complete 20 years of service, in order to capitalize on private sector employment opportunities—and pensions. The result is a system which pays relatively high benefits to a disproportionately high number of officers when compared to the composition of the military as a whole.

Commentators have periodically called for shorter vesting schedules, comparable to those required for private plans under ERISA, or for other Federal service jobs. Some military manpower experts have argued that such a change would adversely impact the ability to maintain "youth and vigor" in the military work force. On the other hand, some military manpower analysts argue that the need for "youth and vigor" is overstated in view of new technologies which put a premium on technical skills rather than physical endurance.

(C) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan [SBP] was created by legislation enacted on September 21, 1972 (Public Law 92–425). Under this plan, a military retiree can have a portion of his or her retired pay withheld in order to provide, after death, a survivor annuity to a spouse, a spouse and child, child only, person with an "insurable interest," or former spouse. As a result of the SBP, a military retiree can provide for an annuity of up to 55 percent of his or her total retired pay at the time of death to be paid to a surviving spouse. The retiree is automatically enrolled in the plan upon retirement at the maximum rate unless the retiree elects, in writing, not to participate or to do so at a lesser level of protection. If such an election is made, the spouse must be notified. SBP annuities are adjusted for the cost-of-living on the same basis as military retired pay.

(1) Social Security Offset

Coverage of military service under Social Security entitles the surviving spouse of a military retiree to receive Social Security survivor benefits based on the deceased retiree's active duty military service. The military Survivor Benefit Plan is "integrated" with Social Security. Since the original intent of the SBP was to provide a proportion of the deceased military members's retired pay to the surviving spouse, it was considered appropriate that all sources of survivor benefits attributable to military service be included in the survivor benefit computation. As a result, Social Security survivor benefits payable because of military service were subtracted from the SBP, so that, the SBP plus Social Security would provide in combination 55 percent of the retired pay to the surviving spouse.

(2) The "Thurmond Amendment"

Due to the Social Security offset provisions of the 1972 legislation creating the SBP, SBP annuities are reduced in recognition of Social Security widow(er)'s benefits, but were also reduced in cases where surviving spouses of retired military personnel had worked in jobs covered by Social Security and were, therefore, entitled to their own Social Security retirement benefits at age 62. As a result, military SBP annuities were reduced even when Social Security survivor benefits were not payable (and never would be) because the survivor was eligible for his or her own retirement benefits. Because this situation was perceived as unfair, Congress included an amendment to the fiscal year 1985 Department of Defense Authorization Act (Public Law 98–525), sponsored by Senator Thurmond, to limit the Social Security offset against SBP annuities to benefits based on service-connected earnings only. This amendment was scheduled to take effect on September 30, 1985, 1 year after passage of the act.

(3) The Two-Tiered SBP

Two problems were perceived with respect to the Social Security offset provisions. First, the offset is not calculated until the time of death and its impact cannot be calculated at the time of retirement, when the decision to participate in the plan must be made. Second, the offset provisions are difficult to explain and understand, and they were often perceived as unfairly taking away an earned benefit.

On September 1, 1985, before the "Thurmond Amendment" became effective, Congress passed the 1986 Department of Defense Authorization Act (Public Law 99-145). In this second act, Congress attempted to provide an SBP benefit structure that would eliminate the uncertainty as to the value of future benefits. This new plan was labeled the "two-tier"SBP. Under this plan, a surviving spouse will receive a maximum of 55 percent of military retired pay as a survivor annuity. Upon reaching the age of 62, the SBP annuity will automatically be reduced to 35 percent of military retired pay for all surviving spouses. This offset will occur regardless of whether the survivor is eligible for Social Security retirement or survivors benefits or for no Social Security benefits, and regardless of any other sources of income when the surviving spouse reaches the age of 62. The "two tier" SBP effectively repealed the provisions of the "Thurmond Amendment" before it took effect.

(4) The Continuing Issue

It has been noted that the "two tier" system does not treat SBP annuitants as equitably as the "Thurmond Amendment" would have. Military SBP benefits become payable immediately upon the death of the retiree, regardless of the age of the suviving spouse. Social Security widow(er)'s benefits are not paid until the survivor reaches age 60, while retirement benefits for a spouse with their own earnings record do not begin until age 62.

Under the "two tier" system, if a surviving spouse is, for example, age 57 at the time of the retiree's death, full SBP benefits are payable at that point. These benefits will continue at the same level until the survivor reaches age 62. For surviving spouses without their own Social Security earning record, may draw Social Security widow(er)'s benefits for 2 full years before their SBP annuity is reduced. Survivors who will receive their own retirement benefits from Social Security must wait for them until age 62, the point at which their SBP annuity is reduced. For survivors who are not eligible for any Social Security benefits, their SBP annuities will be reduced even if they do not have additional retirement income coming in by the time they reach age 62.

This difference in treatment of survivors may lead to future legislative activity in this area. Although the "two-tier" SBP does provide certainty as to benefits payable, the fact that it may result in less than optimal targeting of limited Federal funds make it ripe for further changes as Congress continues to cope with mounting deficits.

3. Legislative Activity in 1986

(A) THE MILITARY RETIREMENT REFORM ACT

After years of debate over the restructuring of the military retirement system, congressional armed service committees developed a new retirement system in the Military Retirement Reform

Act of 1986 (Public Law 99-348). This act, signed into law on July 1, 1986, effects only those personnel who first enter military service on or after August 1, 1986. The new system decreases the multiplier for those that retire after 20 years from 2.5 percent to 2.0 percent, and increases the multiplier for those that retire after 20 years from 2.5 percent to 3.5 percent. The purpose of the new legislation is twofold. First, the act is aimed at containing the costs of the military retirement system. Second, the act intends to provide incentives to encourage experienced military personnel—those with 20 years or more of service—to remain on active duty.

It accomplishes these objectives by "skewing" the multiplier so as to favor the longer serving military personnel. Under the previous military retirement system, retired pay was computed at 2.5 percent of the computation base for each year of service. This method did not substantially differentiate between people who retired after the mandatory 20 years and those that stayed longer. Since most military personnel retire after 20 years, the cut from 2.5 percent to 2.0 percent will save the Federal Govenment money.

Another aspect of the new act which is designed to effectuate cost savings for the Federal Government is a provision to maintain the cost-of-living [COLA] increases at a level 1 percentage point below the actual inflation rate. The combined effect of these cost-saving measures will be to save the Federal Government $5 billion in authorizations from 1987 until 1991, according to the Congressional Budget Office. The long term effect of the reduction in the multiplier will be greater as the percentage of surviving personnel under the new plan grows.

(1) Benefit Computation

The act reduces the base pay for computing retired pay. A servicemember becomes entitled to retired pay upon completion of 20 years of service, regardless of age. A member who retires from active duty is paid an immediate monthly annuity based on a percentage of his or her retired pay computation base. The formula provides that retired pay is computed at the rate of 2.5 percent of the computation base for each year of service. For persons who entered military service before September 8, 1980, the retired pay computation base is final monthly pay being received at the time of retirement. For those who entered service on or after September 8, 1980, the retired pay computation base is the average of the highest 3 years of basic pay.

For personnel who first enter military service on or after August 1, 1986, the Military Retirement Reform Act of 1986 made two major changes in the method of computing retired pay. First, the changed formula is "skewed" much more sharply in favor of the longer serving military careerist, providing an incentive to remain on active duty longer before retiring. For retirees under the age of 62, retired pay will be computed at the rate of 2 percent of the retired pay computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. The changed formula, therefore, favors of the longer serving military careerist, providing an incentive to remain on active duty longer before retiring. Second, when a retiree reaches age 62, his or her retired pay be recomputed on the bases of the old formula—a straight 2.5 percent of the retired pay computation base for each year of service. Thus, under the new formula, at age 62, a retiree who served 20 years could receive 40 percent of the computation base for retired pay. Upon turning age 62, that retiree will begin receiving benefits based on 50 percent of his or her original computation base. These changes in the retired pay computation formula apply only to active duty nondisability retirees. Disability retirees and Reserve retirees are not affected.

(2) Cost-of-Living Adjustments

The act reduces future costs by providing that for military personnel who first enter military service on or after August 1, 1986, annual COLA's remain 1 percentage point below the actual inflation rate for retirees under age 62. Once a retiree has obtained age 62, COLA's will be paid at the rate of inflation. These changes in the COLA formula apply to all persons who first enter military service after August 1, 1986—active duty nondisability retirees, disability retirees, and Reserve Component retirees.

(3) Survivor Benefit Plan

While the Military Retirement Reform Act did not directly modify the Survivor Benefit Plan. The formula for computing the amounts continues to be a maximum amount of 55 percent of military retired pay for all surviving spouses, up to the age of 62. After 62, this maximum drops to 35 percent of military retired pay. However, future benefits will be reduced because this formula is not applied to a smaller base (40 percent after 20 years of service), as a result of the Military Retirement Reform Act.

(B) THE FISCAL YEAR 1987 BUDGET

For fiscal year 1987 the Reagan Administration proposed better treatment for military than for civilian retirees. The President's budget proposed canceling the 1987 COLA for both civilian and military retirees. However, the permanent COLA reduction proposed for civil servants, was not applied to military retirees. The COLA cancellation for 1987 was projected to reduce outlays by $0.5 billion in fiscal year 1987, for a total savings of $3.8 billion over 5 years.

Despite the President's budget proposal, congressional action on a fiscal year 1987 budget left military retirement COLA's intact. The House budget resolution (H. Con. Res. 337) assumed payment of the COLA "at the actual rate of inflation." Similar language was used in the Senate budget resolution (S. Con. Res. 120), which was eventually adopted by both Houses in late June. The resulting 1.3 percent increase will result in an average increase of $13.73 per month, bringing average monthly benefits for nondisability annuitants to $1,069.65.

(C) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

As an amendment to this year's budget reconciliation bill, the Senate approved language protecting military retirement benefits (and certain other Federal retirement and disability benefits) from automatic reductions under the Gramm-Rudman-Hollings law. This amendment passed the Senate by voice vote on September 19, 1986. Similar language had passed the House of Representatives as part of the freestanding bill, H.R. 4060, on June 24, 1986, by a vote of 396 to 19. The amendment language became part of the House and Senate conference agreement, adopted by both Houses and eventually signed into law by the President on October 21, 1986 (Public Law 99-509).

This law prevents further automatic cancellation of COLA's under sequestration, but is not a safeguard against all possible COLA reduction measures. Congress retains the power enact legislation to reduce or eliminate military retirement COLA's.

4. Prognosis for 1987

The long debate over the structure of the military retirement system was closed with the passage of the Military Retirement Reform Act of 1986, which set up a new system for new entrants into military service but left the existing system intact for those who had entered military service prior to August 1986. It is doubtful that Congress will undertake major changes to either the old or new systems in the forseeable future.

Two aspects of the military retirement system remain open to possible congressional adjustments in 1987 and beyond—the payment of COLA's to military retirees and survivors, and the benefits structure of the Survivor Benefit Plan. The COLA issue will remain prominent as Congress and the administration continue to wrestle with the question of how best to control Federal deficits without breaking promises or sacrificing important Government services.

E. RAILROAD RETIREMENT SYSTEM

1. Background

The Railroad Retirement System is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with the Social Security System. The system was authorized in 1935, prior to the creation of Social Security, and it remains the only federally administered pension program for a private industry. In covers hundreds of railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of dual vested or so-called "Windfall" benefits, which are paid for through Federal general revenues from a special account. Currently, just under 1 million retirees receive Railroad Retirement benefits, and total payments to these beneficiaries reached $6.2 billion in fiscal year 1986. Rail employment, which determines the financial status of the Railroad Retirement System through payroll tax revenues, has stabilized at a level hovering around 400,000, after dropping precipitously in 1981, 1982, and early 1983.

2. ISSUES

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

The broadest policy issue associated with the Railroad Retirement System is simply: Do we still need and independent, publicly administered railroad pension system? The general structure of the Railroad Retirement System results from its unique development. In order to understand the major issues facing the Railroad Retirement System, it is critical to review this development. In the final quarter of the 19th century, railroad companies were among the largest in America, and were marked by a high degree of organizational centralization and integration. The original Railroad Retirement System was created in 1934 to provide annuities to retirees based on rail earnings and length of service.

The Railroad Retirement Act of 1974 fundamentally reorganized the Railroad Retirement System, and established the outline of its present day organization. Most significantly, the legislation created a two-tier benefit structure in which tier I serves as an equivalent to Social Security, and tier II parallels a private pension. Tier I benefits are computed on credits earned in both rail and nonrail work, while tier II is based solely on railroad employment. The total benefit amounts to traditional railroad annuities, and eliminates duplicate coverage for nonrail service by both Social Security and the Railroad Retirement System.

In its fiscal year 1983 budget, the Reagan Administration proposed dismantling the system, with Social Security absorbing tier I, tier II being coverted into a private pension, administered by a private corporation. This proposal was founded on the assumption that the Government should not administer an industry pension, and that given the equivalency of tier I and Social Security, it is appropriate to combine the two, and create a privately administered pension to complement it, as is the case with other industries.

This proposal was rejected by Congress. Many felt that reorganization would lead to a cut in benefits for present and future retirees, and that if exempted from ERISA standards, as proposed by the administration, employees and retirees would have no guarantee that their full pensions would be provided. It was further argued that such a conversion would exacerbate Social Security's financing problems, and create administrative difficulties for SSA, similar to the creation of SSI, and SSA's assumption of the Black Lung Program.

(B) RECENT FINANCING PROBLEMS

During the 1970's the rail industry performed poorly, and by 1980, the retirement trust fund was faced with the prospect of insolvency. Declining rail traffic, and hence declining employment, led to diminished payroll tax revenues. Since the end of World War II, the worker/beneficiary ratio has been decreasing, as described by the table below:

TABLE 2-1.—EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

Year	Average employment	Retirees	Ratio of actives to retirees
1945	1,689	210	8.04
1950	1,421	461	3.08
1955	1,239	704	1.76
1960	909	883	1.03
1965	753	930	0.81
1970	640	1,052	0.61
1975	548	1,094	0.05
1980	532	1,084	0.49
1981	503	999	0.50
1982	440	988	0.44
1983	390	981	0.40
1984	400	980	0.40
1985	374	954	0.39

Source: Railroad Retirement Board, 1986.

This longer term financing problem grew worse because congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits, and the difference was paid from the Railroad Retirement trust fund.

To improve the system's financial condition, Congress included Railroad Retirement provisions in both the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) and the Economic Recovery Tax Act of 1981 (Public Law 97-34). These amendments raised payroll taxes on employers and employees, modified benefits, created a separate account for "windfall" benefits, and provided the Railroad Retirement trust fund with authority to borrow funds from the General Treasury, when near term cash flow difficulties arise.

Unfortunately, an economic recession devastated the railroad industry in the final quarter of 1982, bringing the Railroad Retirement System once again to the brink of insolvency.

Early in 1983, rail labor and management collectively negotiated a comprehensive financing package and submitted it to Congress. This agreement was considered by Congress, revised, and ultimately enacted in August 1983. The final package composed of payroll tax increases, benefit reductions, and Federal contributions. Passage averted a 40 percent reduction in tier II benefits scheduled for October 1, 1983.

Key provisions of the Railroad Retirement Solvency Act of 1983 (Public Law 98-76) included the following:

1. A COLA offset provision, which required that the next 5 percent of tier 1 (Social Security equivalent) COLA increases be subtracted, dollar for dollar, from tier II (pension) benefits. This effectively eliminated the 3.5 percent COLA scheduled for January 1984, and reduced the 1985 COLA from 3.5 percent to 2 percent. Justification for the COLA reduction came from the belief that the burden of producing solvency for the system should fall on management, labor, and retirees—management and labor through increased taxes, and retirees through reduced benefits.

2. The so-called 60/30 benefit, which allows employees with 30 years of service to retire at age 60 without benefit reduction, was scheduled to be phased out.

3. Three annual 0.75-percent payroll tax increases were levied on rail employees, and 3 annual 1-percent payroll tax increases were levied on rail employers. This provision raised total payroll taxes from 13.75 percent to 19 percent.

4. The wage base on which the employer-paid tax railroad unemployment insurance tax paid by employers is levied was increased by 50 percent from the first $400 of monthly earnings to the first $600. A temporary unemployment tax was levied on employers on July 1, 1986, to repay a debt owed by the unemployment account to the retirement fund.

5. Tier II benefits and vested dual or "windfall" benefits were made subject to Federal income taxation under the same guidelines as private pension earnings—i.e., to the extent the pension income exceeds the employee's contributions. The revenue collected from this taxation will be transferred to the rail trust fund to finance benefits payments, through 1989. After that point, the revenues will remain with the Federal Treasury.

Overall, the Railroad Retirement Solvency Act of 1983, through a combination of tax increases, benefit adjustments, and Federal assistance was designed to guarantee the solvency of the Railroad Retirement System through the 1990's, even under pessimistic employment assumptions. Projections by the Railroad Retirement Board in January 1987 show the funds to be solvent through 1992. Further, it is expected that in the future, the worker/retiree ratio will increase, as the peak in number of retirees passed.

The legislation is not without its critics, however, and it is important to point out some of the weakness in the law. For instance, the COLA offset provision could not be accomplished if the tier II benefit component were truly were an industry pension, and subject to ERISA regulations. To take funds from tier II to offset increases in tier I benefits partially undermines the basic assumption of the 1974 reorganization. The abrupt phase-out of 60/30 benefits jeopardizes the plans of older rail employees who had conceived their retirement on benefit assumptions that have been rendered invalid. To rapidly change the rules in mid-stream is inequitable to employees nearing retirement. Finally the tax treatment of "windfall" benefits as equivalent to pension benefits is inconsistent with the fact that "windfall" payments accrue from Social Security coverage. "Windfall" benefits should be taxed like Social Security benefits, not like returns from a private pension.

(C) TAXATION OF BENEFITS

In recent years, questions have been raised as to the tax treatment of railroad retirement benefits. The existing taxation structure taxed tier I benefits as if they were Social Security benefits—half of tier I benefits are taxed to the extent that, combined with other income, they exceed a threshold amount ($25,000 for individuals and $32,000 for couples), and tier II benefits were taxed as private pension benefits.

Some advocated amending the tax treatment of tier I benefits because of certain features of the Railroad Retirement System which can result in tier I benefits being larger than Social Security benefits for other workers with similar employment records. One such rule allows workers to retire at 60 if they have 30 years of rail employment. Another rule allows workers to qualify for disability payment under standards that are less stringent than those for Social Security Disability Insurance.

The Treasury Department advocated splitting the tier I benefit into 2 parts—tier I-A would be equal to Social Security benefits and tier I-B would be equal to any excess—and taxing I-A benefits exactly as Social Security while taxing I-B benefits as identical to tier II pension benefits. Proponents of the measure argued that it equalized the treatment of workers under both the Social Security and Railroad Retirement Systems.

Critics of the change argued against it on several grounds. First, they believed that the new tax followed too closely on the heels of other recent taxes on and cuts in the retirement program. Second, the complexity of the plan to create further sub-categories in benefits would create difficulties for recipients and for the Railroad Retirement Board. Third, despite being labeled a tax measure, the proposal amounted to a benefit cut for people on fixed incomes who had already made retirement plans based on earlier payment levels. Fourth, the proposal was not considered in the context of tax reform legislation, which would have clarified its impact on tax and retirement policy.

(D) BENEFIT QUALIFICATION ISSUES

The Railroad Retirement System contains numerous unique benefit qualification rules which distinguish tier I benefits from those provided by Social Security, and which distinguish tier II from most private pension systems. Since railroad retirement takes the place of these systems, the presence of the unique rules has led critics to call for their removal.

One frequently criticized rule is the "last person service" requirement for tier II benefits. This rule requires that a worker leave his current employment before he can collect benefits, regardless of whether his current employment is in the rail industry. Private pensions require that workers leave current covered employment before receiving their pensions, but they do not require that workers leave current employment which is unrelated to their covered employment.

Other criticized rules which do not comport with Social Security or private pension practice include limits on the eligibility of divorced spouses for benefits, inadequate credit for periods of military service, and no allowance for trial work periods before annuities are reduced.

(E) SOLVENCY OF THE RAILROAD UNEMPLOYMENT INSURANCE SYSTEM [RUI]

The RUI system is insolvent, and has borrowed money to pay benefits from the retirement system for 20 of the last 25 years. In the past, these loans were used to bridge short-term cash flow problems in the RUI program, and were repaid with interest. However, drastic increases in rail unemployment in the past few years has led to more protracted and more extensive borrowing from the retirement fund. By July 1984, the RUI system owed more than $700 million to the retirement account. It was expected that this debt would reach $1 billion in fiscal year 1986. Without major changes in the financing of the RUI system, it is unlikely that this debt could ever be serviced.

The 1983 Retirement Solvency Act created a Railroad Unemployment Compensation [RUC] Committee to study the RUI problem and make recommendations to Congress to either restore solvency to the RUI system or to fold it into the Federal-State Unemployment Compensation System.

The RUC panel presented two alternative proposals in its June 1985 report. A majority of this panel, consisting of the two labor members and the chairman, recommended keeping a separate rail unemployment insurance system. The two management members advocated a transfer of the RUI system to the States, and provided a proposal to accomplish this in a fashion acceptable to rail companies. The management representatives joined the majority in shaping a "consensus" package of specific recommendations for saving the RUI system. Management pledged its support to the consensus package in the event that Congress rejected the management proposal.

Under the consensus package, a separate RUI system would be retained and solvency would be restored through a number of financing changes. From the standpoint of retirement fund, the most critical provision in the consensus proposal is a waiver of all interest on principal owed by the RUI account from past loans. Waiving the interest on $1 billion of debt, which would be paid over a period extending to the year 2000, would represent a serious financial sacrifice by the retirement account to the unemployment system. This provision pits the interests of younger employees, faced with prospect of continued spells of high unemployment, against the concerns of retirees.

Independent of the RUC committee, the Reagan Administration proposed its own legislative package to phase in a transfer the RUI system to the State unemployment compensation programs.

As a matter of railroad retirement policy, the critical issue is how will the enormous debt owed by the RUI system be paid, and more specifically, will the retirement account recoup the interest owed on that debt over time.

(F) THE GRAMM-RUDMAN-HOLLINGS ACT

The Gramm-Rudman-Hollings Act is designed to reduce the deficit by instituting automatic spending cuts in a large portion of Federal spending programs if pre-set deficit reduction goals are not met. In March 1986, the first round of cuts went into effect, reducing outlays in the targeted programs by 4.3 percent for fiscal year 1986.

The automatic cuts affect the Railroad Retirement System in several different ways. First, the administrative budget of the Railroad Retirement Board was subject to the full 4.3 percent cut resulting under the act. Second, tier 1 benefits were treated like Social Security in that they were exempted from cuts and they received the 3.1 percent COLA that was due. Third, tier 2 benefits received the same treatment as Federal pensions for retired Federal and military employees—benefits were not reduced from earlier levels, but the scheduled 1986 COLA was cancelled. Fourth, supplemental benefits, which receive no COLA, were not reduced, because they are paid out of the same budget account as tier 1 benefits. Fifth, vested dual benefits, which do not receive a COLA, were subject to the 4.3 percent cut mandated by Gramm-Rudman.

While many protested the freeze on the Tier 2 COLA, the cut in vested dual benefits created the most controversy. This was partly because it appeared to be an oversight on the part of the Congress, which was on record as intending to do no more than freeze retirement benefits. Additional controversy resulted because the 4.3 percent cut was announced on April 1, and had to be implemented in the middle of a fiscal year, which resulted in that portion of monthly checks attributable to vested dual benefits dropping by 7.8 percent for the remainder of the fiscal year. Among the 310,000 who received these benefits, averaging $104 per month, the cut amounted to a loss of $8 per month.

3. Legislation

The Railroad Retirement System was the subject of comparatively minor congressional attention during 1986. Following the passage of the Railroad Retirement Solvency Act in August of 1983 (Public Law 98-76), which restored short- and long-term solvency to the Railroad Retirement System through a combination of tax increases, benefit reductions, and Federal financing, there was little impetus for major legislative action in the 99th Congress.

(A) RAILROAD UNEMPLOYMENT INSURANCE

One subject left unresolved by the comprehensive legislative package enacted in 1983, however, was the insolvency of the Railroad Unemployment Insurance [RUI] Program. The 1983 legislation did establish a Railroad Unemployment Compensation [RUC] Committee, composed of representatives of rail labor, management, and the general public, to examine the conditon of the RUI program, and make recommendations to Congress to redress the system's financial crisis. The RUC made its report on June 29, 1984. Congress subsequently developed its own solution to the Railroad Unemployment Insurance [RUI] crisis and included its provisions in the Consolidated Omnibus Budget Reconciliation Act (Public Law 99-372), passed in April 1986.

The solution developed by Congress departed significantly from the proposals of the Railroad Unemployment Commission, and from administration proposals. The key provisions of the congressional proposal are the following.

1. The retirement fund will not forgive the interest on its loan to the unemployment fund.
2. Financing of the loan repayment will come from an increase in the existing loan repayment tax that the 1983 railroad retirement tax imposed on employers for the years 1986

to 1990. This tax applies to the first $7,000 of annual wages to each rail employee. Effective June 30, 1986, the 1986 tax will increase from 2 percent of payroll to 4.3 percent; the 1987 tax will increase from 2.3 percent to 4.7 percent; the 1988 tax will increase from 2.6 percent to 6 percent; the 1989 tax will remain at 2.9 percent; and the 1990 tax will remain at 3.2 percent.

3. Any new loans from the retirement fund will be paid by an additional 3.5 percent surtax if the existing tax receipts do not cover the loan.

4. The unemployment fund will receive permanent authority to borrow from the retirement fund. This replaces the temporary authority that expired on December 19, 1985.

5. No alterations in unemployment benefits were made.

(B) BUDGET LEGISLATION

Congress also resolved the threat to benefits posed by the Gramm-Rudman-Hollings Act. Senator Heinz introduced S. 2209 to exempt vested dual benefits from further cuts under the automatic sequestration process. This bill was later added as an amendment to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) and enacted into law. Individual vested dual benefits were restored to their pre-Gramm-Rudman levels by the 1986 continuing resolution (Public Law 98-500). Senator Gorton introduced an amendment to the reconciliation that exempted tier II COLA's from further freezes under Gramm-Rudman. No effort was made to restore the COLA that was frozen in 1986.

Beginning in January 1987, retirees will receive benefits with fully-indexed COLA's. The Social Security equivalent benefits will be increased by 1.3 percent, and tier II pension benefits will receive a 0.4-percent increase. These COLA's are significantly lower than those granted in recent years because of low inflationary rates in 1986.

(C) TAXATION OF BENEFITS

As part of the Consolidated Omnibus Budget Reconciliation Act of 1985, signed into law April 7, 1986, Congress restructured the taxation of railroad retirement benefits. The existing taxation structure taxed tier I benefits as if they were Social Security benefits—half of tier 1 benefits are taxed to the extent that, combined with other income, they exceed a threshold amount ($25,000 for individuals and $32,000 for couples), and tier II benefits were taxed as private pension benefits.

The change in the tax treatment are consistent with the effort to treat tier 1 exactly like Social Security. The bill follows an administration proposal and divides tier I benefits into two components, often referred to as tier I-A and tier I-B. Tier I-A is the amount that is identical to benefits which the worker would have earned under Social Security had his entire career been in nonrail employment. Tier I-B is the amount of extra benefits which result from the rail system's unique qualification rules. One such rule allows workers to retire at 60 if they have 30 years of rail employment. Another rule allows workers to qualify for disability payments under standards that are less stringent than those for Social Security Disability Insurance. Tier 1-B benefits will now be taxed in the same manner as tier 2. The Treasury Department estimated that taxation of tier I-B benefits would produce $160 million annually.

4. Prognosis

After year of uncertainty the Railroad Retirement System appears to have weathered the most serious crises in its history. the changes wrought in the past few years have assuerd adequate financing of the retirement fund and the unemployment fund. Barring a serious recession in the rail industry, or other developments which would drastically alter the ratio of workers to retirees, the system should be able to pay its own way for the forseeable future. Any future legislative activity in the retirement area will probably focus on attempts to eliminate the qualification rules that have developed as the system grew, and which set the system apart from Social Security and private pension systems.

The effect of the Gramm-Rudman-Hollings Act on the Railroad Retirement System is difficult to predict. While all four benefit components—tier I, tier II, supplemental, and vested dual benefits—are insulated from the automatic spending cuts set forth in the Gramm-Rudman-Hollings Act, Congress might nonetheless cut these benefits in an effort to voluntarily meet its deficit reduction targets, thus avoiding mandatory cuts in other programs.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

Older Americans have benefited from special tax advantages since tax-free Social Security benefits were first paid in 1940. The exclusion of Social Security income and other tax advantages enacted subsequently were intended to extend the purchasing power of the limited cash resources the elderly received. Calls for reform of the tax structure to increase tax equity, and a concern by some that all elderly are not in need of special tax treatment brought tax advantages for the elderly under review as Congress developed the Tax Reform Act of 1986.

The first concrete signs of a change in attitude about special tax provisions for the elderly appeared with the enactment of the Social Security Amendments of 1983. As part of a package of changes to solve Social Security financing problems, the 1983 amendments made Social Security and railroad retirement benefits taxable for the first time—generally taxing half of the benefit for those who have substantial income from other sources. The 1983 amendments also eliminated a special tax credit previously available to retired public employees younger than 65 years of age. The most significant effect of the change was to increase tax liability by as much as 2 percent of income for the 10 percent of the elderly taxpayers with the highest incomes.

Legislation in recent years to raise Federal revenues and improve tax equity through broadening of the tax base and greater taxpayer compliance has also changed the way the elderly pay some of their taxes. In the Tax Equity and Fiscal Responsibility Act of 1982, Congress reduced the obligation to estimate and pay quarterly taxes on pension and interest income by requiring payors of pension annuities and interest to withhold taxes. While pension withholding has remained in effect, public pressure forced the repeal of withholding on interest and dividend income in 1983. As part of the Deficit Reduction Act of 1984 [DEFRA], the Congress provided the Secretary of the Treasury with greater discretion to waive penalties for elderly and other taxpayers, who, through ignorance of the requirement, fail to file estimated quarterly tax payments.

In 1985, attention turned to the efforts for comprehensive reform to reduce the complexity and improve the fairness of the tax code. In November 1984 the Treasury provided a proposal to the President for tax reform, universally known as Treasury I. In May 1985 the President submitted a revised proposal to the Congress. Both the President's proposals included reductions and eliminations of many current deductions, accompanied by reduced overall tax rates and a broadening of the tax base. Some of these proposals would have eliminated one or more special exemptions or deductions for the elderly, while leaving the Social Security exemption and other special provisions in place.

On December 17, 1985, the House of Representatives passed a comprehensive tax bill, which retained current law treatment of Social Security and railroad retirement benefits and certain other provisions of benefit to the elderly. The bill did, however, call for the elimination of the extra personal exemption available to elderly and blind taxpayers. The effect of this provision on the elderly was counteracted to some extent by increases in the personal exemption for all taxpayers and a special standard deduction for the elderly which was higher than that for other taxpayers.

On June 24, 1986, the Senate passed its own version of H.R. 3838, a sweeping bill which significantly lowered tax rates and eliminated many deductions and credits. Like the House bill, it eliminated the extra personal exemption for elderly and blind taxpayers, included an additional standard deduction for the elderly and blind, and retained current law with respect to the taxation of Social Security and railroad retirement benefits. The Senate bill differed from the House bill in several areas of concern to elderly taxpayers—the charitable deduction was allowed to expire for nonitemizers, the deduction for State and local taxes was limited, and the medical deduction was lowered from amounts over 5 percent of adjusted gross income [AGI] to amounts over 9 percent of AGI.

Compromise was reached in the fall, and the Tax Reform Act of 1986 was signed into law on October 22, 1986. The new law contains the changes to personal exemptions and standard deductions included in both bills. The individual tax rates were set at 15 and 28 percent. The charitable expense deduction was eliminated for nonitemizers and the medical expense deduction will only be available to the extent such expenses exceed 7.5 percent of AGI. Although the capital gains treatment was repealed, the one-time exclusion of gains on the sale of a residence for persons age 55 or older was left intact. The deductions for State and local sales taxes and the income-averaging method of computing income tax were repealed.

The changing attitude toward tax advantages for the elderly has been accompanied by a shift in Federal policy concerning savings and investment. As part of a national strategy to increase capital available for investment, tax incentives for corporate and personal savings were expanded by the Economic Recovery Tax Act of 1981. Although some analysts have suggested that increased receipt of asset income would improve retirement income adequacy, most of these incentives were not directed solely at improving retirement income.

There is now an increasing awareness of the cost of tax incentives for savings and assest accumulation, and a growing doubt about the contribution of additional savings incentives toward capital formation and retirement income. Some believe that tax-favored treatment does not result in new savings for retirement, but simply encourages individuals who already have after tax savings to shift those savings into tax-favored vehicles. To the extent that this is true, it gives a windfall to those taxpayers and raises serious questions as to the efficiency of this incentive.

The Tax Reform Act of 1986 embodied this new concern about the efficiency of tax-favored savings by limiting the availability of the tax deduction for contributions to an Individual Retirement Account [IRA] to lower paid workers and workers without pension plans. In effect, the change in the IRA deduction represented a move back to the pre-ERTA concept of voluntary savings as a way to fill the gap in pensions and supplement limited pension income, rather than as a means for building retirement income for its own sake.

A. TAXES

1. Background

Concern about the special tax treatment accorded those 65 and older focuses on whether existing provisions are equitable and whether they serve a worthwhile purpose. Prior to enactment of the Tax Reform Act of 1986, four tax provisions exclusively benefited older persons and others who receive Federal benefits: (1) The exclusion of Social Security and railroad retirement benefits (for those with adjusted gross incomes below specified levels), and the exclusion of veteran's benefits; (2) the additional exemption of persons 65 and older; (3) the 15 percent elderly tax credit for disabled and elderly persons with limited incomes; and (4) the one-time exclusion of $125,000 in capital gains from the sale of a home after age 55. The elderly also benefit from tax provisions that are not age-specific, such as medical expense deductions, State and local bond interest exclusion, and deductions for charitable contributions.

Social Security, railroad retirement, and veterans benefits prior to 1983 were, like many other Government transfer payments, exempt from taxation. The original Social Security legislation made no specific reference to the tax treatment of benefits. However, a revenue ruling was issued at the time benefits were first paid, stating: (1) that Congress did not intend for Social Security benefits to be taxed since it did not include a provision to tax them in the law, and (2) that the benefits were intended as gratuities and not earnings-related annuities, and therefore, were not taxable.

(A) TAXATION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

In 1983, the Congress enacted legislation to restore financial solvency to Social Security (Public Law 98-21). A provision to tax half of the Social Security and railroad retirement benefits of those whose combined income exceeded $25,000 for single filers and $32,000 for joint filers was included in that legislation. The rationale for this change was to treat Social Security and railroad retirement the same as employer-sponsored pensions for tax purposes, by excluding from taxation only the portion of the benefit attributable for after-tax employee contributions. The limit on taxability protected low- and moderate-income beneficiaries from a sudden increase in tax payments. Full taxation of benefits will phase-in gradually for those whose income are now below the fixed limits when, over time, their incomes rise as the limits remain the same.

(B) EXTRA PERSONAL EXEMPTION FOR ELDERLY, BLIND, AND DISABLED

The extra personal exemption for taxpayers 65 and older was added to the tax code in the Revenue Act of 1948 to compensate for preceived economic handicaps of the elderly, as well as to provide some relief from the effects of the post-war economy. The elderly were provided special treatment because they could not benefit from the rapid wage gains being realized by workers in the post-war economy. At the time it was enacted, this provision removed an estimated 1.4 million elderly taxpayers from the rolls, and reduced the tax burden for another 3.7 million.[1]

(C) ELDERLY TAX CREDIT

The retirement income credit was enacted with the codification of the Internal Revenue Code [IRC] in 1954. The purpose of the credit was to extend tax treatment parallel to the exemption of Social Security income to those whose retirement income came primarily fron non-Social Security covered employment or from independent savings. Persons 65 and older or under 65 and receiving a public pension were allowed to take a tax credit equal to 15 percent of their pension (and, in the case of those 65 and older, interest and dividend) income. The amount of retirement income qualifying for the tax credit did not include earned income over certain limits nor Social Security or other tax-exempt benefits. In 1976, the Congress limited the credit to those 65 and older with low incomes and renamed it the Elderly Tax Credit. (Targeting was achieved by placing a ceiling on the amount of the credit and by reducing the amount credited for tax-exempt retirement income and adjusted gross earnings.) The credit for those under 65 was not modified in 1976, but was eliminated in the 1983 Social Security amendments. At the same time, the tax credits for those 65 and older was increased by doubling the maximum tax credit amount.

(D) ONE-TIME EXCLUSION OF CAPITAL GAINS ON SALE OF HOME

The one-time home sale capital gains exclusion originated in the Revenue Act of 1964. At the time it was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation. In addition, advocates maintained that the Government should not tax away assets people had accumulated for retirement nor discourage the elderly from selling their homes. The capital gains tax was seen as a substantial burden for the elderly in the case of home sales. Originally the provision excluded capital gains of $20,000 in the adjusted sales price of the house for persons 65 and older. In recent years, the Congress raised the maximum excludable gain to $125,000 to reflect increases in average market prices for housing, and lowered the age at which the exclusion can be taken to 55.

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[1] U.S. Congress. Senate. Committee on Finance. Revenue Act of 1948; Report to accompany H.R. 4790. 80th Cong., 2nd Sess., Washington: U.S. Govt. Print. Off., 1948, p. 21.

2. TAX INCIDENCE AMONG THE ELDERLY [2]

These exclusions and deductions enable many of the elderly to pay no taxes at all. In 1984, persons 65 and older filed nearly 9.9 million taxable returns,[3] while 71.8 million taxable returns were filed by individuals and couples under age 65. The elderly who do pay taxes, however, pay higher taxes on average than the nonelderly. Elderly taxpayers in 1984 had higher effective tax rates (16.8 percent) and greater tax liability ($4,253) than nonelderly taxpayers (14.1 percent and $3,622 respectively), despite the fact that the average adjusted gross income [AGI] of elderly taxpayers ($25,267) was slightly lower than the average AGI for nonelderly taxpayers.

The difference in tax liability may be due in part to a greater tendency among the elderly to claim the standard deduction rather than to itemize. In 1984, 38 percent of the elderly itemized their deductions, compared to 45 percent of the nonelderly. In addition, those elderly who did itemize claimed an average deduction of $9,250, while nonelderly itemizers claimed an average $9,333.

3. ISSUES

(A) TAX EQUITY AND EFFICIENCY

Before passage of the Tax Reform Act of 1986, tax policy analysts were concerned that the existing income tax system, with its complex array of exemptions and deductions, caused distortions in economic incentives, inequities in the distribution of the tax burden, and too many opportunities for tax sheltering. The fairness of a tax system is usually judged in terms of vertical and horizontal equity. Vertical equity means that tax burdens are distributed in relation to the taxpayer's ability to pay—those with more income pay higher proportional taxes. Horizontal equity means that individuals with equal income have equal tax burdens. The existing progressive income tax had a fair degree of vertical equity, but the complex system of exemptions and deductions results in substantial horizontal inequity.

Generally, the special tax provisions for the elderly were not considered to be inequitable. A 1982 Treasury Department study examined the distribution of tax benefits among higher income groups. The study ranked tax expenditures in terms of the percentage received by taxpayers with 1981 adjusted gross income [AGI] exceeding $50,000. Overall, the 4.4 percent of the taxpayers had more than $50,000 in AGI and these taxpayers paid 32.9 percent of taxes after credits. The study found that of the tax provisions specifically benefiting the elderly, the most regressive was the one-time exclusion of capital gains from home sales. This tax benefit was ranked the 16th most regressive among the 33 benefits studied—27.6 percent of its benefits went to taxpayers with AGI's in excess of $50,000. The double exemption for the elderly was ranked 22d in regressivity, 15.2 percent went to the highest income brackets. The most progressive of the special elderly provisions, the Elderly Tax

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[2] Data in this section is taken from tables in IRS Statistics of Income, 1948 Individual Tax Returns, Washington, DC, 1986.

[3] This number represents filings by 15.9 million taxpayers over age 65, as well as 2.6 million spouses under the age of 65.

Credit, was ranked 30th out of 33 benefits. Only 2.2 percent of its benefits went to those with AGI's in excess of $50,000.[4]

There was a growing sense, however, that the tax system in general benefited the rich at the expense of working people and that this sense of unfairness contributed to a decline in taxpayer compliance. Tax legislation to raise tax revenues to reduce the budget deficit has attempted in recent years to respond to these concerns. In the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], the Deficit Reduction Act of 1984 [DEFRA], and most recently with the enactment of the Tax Reform Act of 1986, the Congress focused on closing tax "loopholes," broadening the tax base by including more items in taxable income, limiting exemptions and deductions, and improving taxpayer compliance. These revenue-raising "reforms" have largely been promoted as means of improving the fairness of the income tax.

The efficiency of the individual income tax is judged in terms of its effects on relative prices and the allocation of resources. Any income tax distorts relative prices and is inherently inefficient. However, tax exemptions and deductions are specifically designed to alter relative prices, often to achieve particular social policy goals. They often have unintended effects on labor supply and consumption which do not contribute to social policy aims. Tax reform efforts to simplify the tax code, lower marginal tax rates and eliminate many current tax deductions and exemptions were promoted as a way to reduce the work and savings disincentives which some believed were inherent in the existing tax system. Proponents of reform argued that the progressive tax structure resulted in high marginal tax rates which discouraged people from working additional hours or raising their gross incomes. A flat tax rate would eliminate the effect of taxing additional income at higher marginal rates. Some argued that a reduction in marginal tax rates would improve the after-tax rate of return on investment and encourage savings.

(B) SIMPLICITY

The existing tax law with its host of exemptions and deductions had become increasingly complex and costly to administer. The diversity of regulations, forms, and procedures confused taxpayers, and reduced compliance with the law. As a result, the administrative requirements and tax losses become increasingly costly to both the Federal budget and the economy.

The tax law is not uniquely complex for the elderly, but the elderly especially can become confused by changes in their tax liability resulting from changes in their status. Retirement often results in a change in the sources and tax treatment of income. The tax rules that become applicable can be confusing, particularly since the tax treatment of some income may change over time or be subject to alternative rules. For exemple, pension income has been taxed under one of two alternative rules which permit the recovery of employee contributions tax-free while taxing employer contributions and earnings on the trust. Individuals who have all of their taxes withheld from their wages or who have claimed only the standard deduction during their working lives may not be prepared to minimize their tax liability on pension and asset income, or accurately file estimated quarterly tax payments during the taxable year.

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[4] Joint Economic Committee, Treasury Study on the Distribution of Tax Expenditures, Nov. 20, 1982.

4. LEGISLATION

(A) INTRODUCTION

The debate over the fairness and simplicity of the tax code resulted in several comprehensive proposals to replace the existing progressive structure with flat tax rates and a broader definition of taxable income. Two prominent proposals from the 98th Congress, the Bradley-Gephardt "Fair Tax Act" and the Kemp-Kasten "Fair and Simple Tax" were reintroduced in the 99th Congress. President Reagan released his own "Tax Proposals to Congress for Fairness, Growth, and Simplicity" in May 1985, beginning his second term with a promise of bringing tax reform to the Nation.

The various proposals had several common themes. They were grounded in an effort to improve the fairness or perceived fairness of the tax system. This was achieved largely through an expansion of the tax base: Counting some noncash compensation (employee benefits and fringes) as income and eliminating tax deductions and exclusions often only available to and certainly worth more to high-income taxpayers. In addition, the proposals sought to simplify taxation—to reduce the need for ordinary taxpayers to maintain detailed records or pay for professional assistance, and make it easier for people to comply with the law. This was achieved largely by the use of a flat-rate tax and the elimination of some tax deductions. The proposals had also, to a greater or lesser degree, avoided redistributing the tax burden across income classes. Finally, all three proposals have aimed at "revenue neutrality," that is, neither increasing nor decreasing Federal revenue, redistributing the tax burden from individuals to corporations or from itemizers to nonitemizers. Yet, despite their broad similarities, these proposals differed on a number of points. Most notably, tax rates, the tax treatment of Social Security, personal exemptions, tax credits for the elderly and disabled, and itemized deductions.

On balance flat-tax proposals would generally lower effective tax rates for people who take standard deductions, increasing effective rates for those who have itemized. Since the elderly are more likely to take standard deductions, tax reform held the potential for actually reducing the net tax burden on the elderly as a group. According to Treasury Department estimates, the President's proposal, with its revised personal exemption and increased elderly tax credit, would raise the level of tax-free income to the elderly.

(B) H.R. 3838: THE HOUSE VERSION

In late November 1985, the House Ways and Means Committee completed work on a comprehensive tax reform bill, H.R. 3838, and brought it to the House floor where it was passed on December 17. The House bill differed from the President's proposal in that it generally reduced taxes for individuals, particularly lower income taxpayers, raised the top tax rate, and raised additional corporate taxes through a minimum corporate tax.

The major provisions of concern to the elderly in H.R. 3838 included:

—The current law of 15 tax brackets and 50 percent maximum rate for individuals was replaced by 4 tax brackets and maximum rate of 38 percent;

—The existing treatment of Social Security and railroad retirement benefits was retained;

—The extra personal exemption for elderly and blind taxpayers was eliminated;

—The value of the personal exemption for taxpayers who do not itemize deductions was increased to $2,000, and to $1,500 for taxpayers who do itemize;

—The standard deduction for elderly taxpayers was raised $600 above the increase for all taxpayers. (The standard deduction is unavailable to taxpayers who itemize.)

—For the most part, itemized deductions of particular interest to the elderly—mortgage interest and the deduction for State and local taxes—remained virtually the same as under existing law.

—The deduction for charitable contributions was made permanent for nonitemizers. (This provision was due to expire after 1986 under existing law.)

H.R. 3838 was generally more generous to lower income taxpayers than the President's proposal, although this generosity was concentrated largely on the nonelderly poor. The Joint Tax Committee reported that H.R. 3838 reduced the tax burden for the lowest income bracket by more than 75 percent. Accordingly to Robert Greenstein, director of the Center for Budget and Policy Priorities, H.R. 3838 was more generous to the low income because of the increase in the standard deduction, and in the earned income tax credit which goes to working families to offset the Social Security payroll tax.[5] Critics of the legislation charged that although the legislation would result in some far-reaching changes, the bill was not truly tax reform since it did little to change the complicated scheme of deductions and exclusions.

(C) H.R. 3838: THE SENATE VERSION

On May 7, 1986, the Senate Finance Committee approved its own sweeping version of tax reform legislation. The full Senate approved this plan on June 24, 1986, by a vote of 97 to 3, as a substitute for H.R. 3838. The Senate bill contained two low tax rates for individuals, a single corporate rate, a corporate alternative minimum tax and elimination of many deductions and credits. The bill was hailed by many as a serious effort to reform the tax code and eliminate special interest features.

The major provisions of concern to the elderly in the Senate's version of H.R. 3838 included:

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[5] Congressional Quarterly, Nov. 30, 1985, p. 2491.

—Two tax rates would apply to individuals—15 and 27 percent (80 percent of taxpayers would be subject to the lower rate);
—The existing treatment of Social Security and railroad retirement benefits was retained;
—The extra personal exemption for elderly and blind taxpayers was eliminated;
—The value of the personal exemption for taxpayers who do not itemize deductions was increased to $2,000, and to $1,500 for taxpayers who do itemize. (These amounts to be phased-in through 1989, and adjusted for inflation thereafter.);
—The standard deduction for elderly taxpayers was raised $600 above the increase for all taxpayers. (The standard deduction is unavailable to taxpayers who itemize.);
—The deduction for State and local sales taxes was limited to 60 percent of the excess of such taxes over the amount of State and local income taxes paid or accrued by the taxpayer over the year;
—The existing provisions regarding the deductibility of charitable contributions was kept—no deduction for nonitemizers after 1986;
—Medical expenses could only be deducted to the extent that they exceeded 9 percent of AGI (the existing measure was 5 percent of AGI);
—Income-averaging provisions were eliminated for all taxpayers except farmers.

(D) THE TAX REFORM ACT OF 1986

The Senate bill, with its sharp reduction in rates and elimination of many special interest tax incentives caught the imagination of the American public. Although there was controversy over some of the provisions, the bill was touted as a great step forward in true tax reform.

Conferees from the two Houses met for 2 months to reconcile differences between the two versions of H.R. 3838. On September 18, 1986, they filed their report, delineating their agreement. The House approved the conference report on September 25, by a vote of 292 to 136, and the Senate followed suit on September 27, 74 to 23. The President signed the bill into law on October 22, 1986. Its provisions will begin to go into effect for 1987, with most of the provisions fully effective for the tax year 1989.

The Tax Reform Act of 1986 made such sweeping changes to the Internal Revenue Code, that the Congress chose to issue the code as a completely new edition (something that has not occurred since 1954). The individual tax rates were kept nearly as low as in the Senate bill—15 and 28 percent. Many deductions and tax credits were eliminated or modified.

(1) Personal Exemptions and Standard Deductions

The new tax code provides for phased-in increases in the personal exemption. In 1987, the personal exemption will be increased to $1,900. In 1988, it will be increased to $1,950, and for years 1990 and beyond, it will be increased to $2,000. Extra exemptions for the blind and those over age 65 are eliminated as of 1987.

To counteract some of the effects of the loss of the extra personal exemption, the elderly and blind will be allowed standard deductions higher than those for other taxpayers.

1987 STANDARD DEDUCTIONS BY FILING STATUS

Filing status	Basic standard deduction	
	Under 65 and not blind	Age 65 or over or blind
Single	$2,540	$3,000
Married filing jointly (use 2d column if either spouse is 65 or older or blind)	3,760	5,000
Married filing separately	1,880	2,500
Head of household	2,540	4,400
Qualifying Widow(er)	3,760	5,000

Source: Highlights of 1986 Tax Changes, Internal Revenue Service, Publication 553, December 1986.

(2) Filing Requirements and Exemptions

Six million additional taxpayers—many of them elderly—will be exempt from filing income tax forms under the new tax law. The 1986 act raises the levels below which persons are exempted from filing Federal income tax forms. Under the new law, single persons age 65 or older do not have to file a return if their income is below $5,650. For married couples filing jointly, the limit is $9,400 if one spouse is age 65 or older, $10,000 if both spouses are 65 or older. Persons who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $500, or, their gross income exceeds their maximum allowable standard deduction ($3,100 for persons age 65 or older or blind, $3,700 for persons who are both 65 or older and blind.)

(3) Taxation of Social Security and Railroad Retirement Benefits

No changes were made to existing provisions governing the income tax treatment of either Social Security benefits or railroad retirement benefits.

(4) Elderly Tax Credit

The Tax Reform Act of 1986 made no changes in the Elderly Tax Credit provisions. Taxpayers age 65 and older will continue to be able to take a credit for up to 15 percent of the retirement benefits they receive from a public pension plan. The maximum amount of credit which can be taken varies with the taxpayer filing status, AGI amounts, and any receipt of Social Security or railroad retirement benefits.

(5) One-time Exclusion of Capital Gains on Sale of Home

The existing provisions regarding the one-time exclusion of capital gains on the sale or exchange of a principal residence for taxpayers age 55 and older was not directly changed by the Tax Reform Act of 1986. The Act did repeal the capital gains provision treatment, so the unexcluded gains realized on the sale of a home would be treated as ordinary income. However, taxpayers over the age of 55 will still have a one-time opportunity to exclude from their income $125,000 of the gain realized from the sale or exchange of their principal residence.

(6) Medical Expense Deduction

Under existing law, medical and dental expenses, including insurance premiums, co-payments and other direct out-of-pocket costs, were deductible to the extent that they exceeded 5 percent of a taxpayer's AGI. The Tax Reform Act of 1986 raises that percentage to 7.5 percent of AGI. This deduction is important to many elderly taxpayers, and the decrease in the amount deductible will adversely affect some elderly taxpayers. How this impact is counterbalanced by certain other features of the new tax law, such as lower tax rates and higher, is unclear at this time.

(7) Repealed Provisions

Among the numerous provisions repealed by the Tax Reform Act of 1986, those of most interest to the elderly include:

—The dividend exclusion of up to $100 per taxpayer;

—The 60 percent exclusion on capital gains (after 1986, capital gains will be treated as ordinary income);

—The deductions for contributions to IRA's by taxpayers above certain income levels who participate in employer-provided pension arrangements (discussed in the Savings section and in Chapter 2);

—The deduction for nonmortgage interest expense will be phased out slowly through 1991;

—The deduction for State and local sales tax; and

—The income-averaging method of computing income tax.

The act made no changes in the deduction for charitable contributions. So, following the existing law, the availability of this deduction for taxpayers who do not itemize their deductions will expire in 1987.

(8) Estate Taxes

The Tax Reform Act of 1986 did not make any major changes in estate and gift tax rules. The minor changes that were made included requirement of estimated tax payments by trusts and estates, and repeal of the rule that permitted estates to elect to pay their income tax in four equal quarterly installments.

5. THE OVER-ALL EFFECT OF TAX REFORM ON THE ELDERLY

A study done for the American Association of Retired Persons found that the elderly will be effected by the Tax Reform Act of 1986 in the following ways:

—Approximately 2 percent of elderly taxpayers will be removed from the tax rolls:

—On average, the tax payments of the elderly will decline about 1 percent, compared with an 8 percent reduction for nonelderly taxpayers. This is explained largely by the loss of the additional exemption for the elderly. It should be noted, however, that under both prior law and the new act, the elderly generally pay a lower percent of their income in taxes than do the nonelderly; and

—Over one-half of all elderly families will see a change in their income tax of less than $20 as a result of the new law. (Many of these are families who pay no taxes under either system.)[6]

On balance, the effect of Tax Reform Act of 1986 on the elderly is favorable. There is a strong incentive for the elderly not to itemize their deductions, which comports with the general goal of simplifying the taxing process. Elderly who do not itemize receive a $600 add-on to the standard deduction. However, the elimination of the extra personal exemption for the elderly, as well as the change in both the personal exemption and standard deduction for all taxpayers who itemize, has the effect of raising taxes for some middle and upper income elderly. Several deductions often used by the elderly have been reduced or eliminated, but lower tax rates may counteract the effects of the loss of these deductions.

With the exception of the $600 add-on to the standard deduction, the act tends to equalize the tax burden for elderly and nonelderly taxpayers with equal income. The elderly receive less favorable treatment than nonelderly taxpayers at similar high-income levels because high-income elderly taxpayers frequently have the types of incomes and deductions facing restricted treatment in the Tax Reform Act of 1986.

B. SAVINGS

1. BACKGROUND

Since 1981 there has been considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: Individuals saving their personal income; businesses retaining their profits; and the Government savings when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal savings and capital accumulation have been enacted in recent years.

At the same time, retirement income experts have suggested that incentives for personal savings be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are primarily dependent on Social Security for their income. Thus some analysts favor a better balance between Social Security, pensions, and personal savings as sources of income for retirees. The growing financial crisis which faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their pre-retirement savings efforts.

The "life-cycle" theory of savings has helped support the sense that personal savings is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings behavior is largely a function of available income versus current consumption needs, an equation which changes over the course of most individuals' lifetimes.[7]

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[6] ICF, Inc., "The Effects of the Tax Reform Act of 1986 on Family Tax Payments in 1990", Final Draft Report to the American Association of Retired Persons, January 1987.

The consequences of the life-cycle savings theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates: Taxpayers who are reaching maturity, earning above-average incomes and subject to relatively high marginal tax rates. Whether this group is presently responding to these incentives by creating new savings, or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a trade-off of increased savings for current consumption, a behavior which they are not under most circumstances inclined to pursue. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially those at the lower end of the income spectrum.

The dual interest in increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement savings over the last decade. However, in recent years, Congress has begun to question the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals, and as a way to create significant net new retirement savings. These issues received attention in 1986 as part of the effort to improve the fairness, simplicity, and efficiency of Federal tax incentives.

The role of savings in providing income in retirement has increased gradually over the last decade as new generations of older Americans with greater assets have reached retirement. In 1984, 28 percent of the total income of the elderly came from assets, compared to only 16 percent in 1962. Fully 68 percent of the elderly had income from assets in 1984, compared to 54 percent in 1962.[8]

The distribution of asset income varies for different subgroups of the elderly. The oldest old are less likely to have asset income than the younger elderly. Only 63 percent of those aged 80 and older had asset income in 1984, compared to 69 percent of those in the 65 to 69 age group. Men are slightly more likely to receive asset income in retirement than women; 72 percent of elderly men have asset income, compared to 67 percent of elderly women. Whites are more than twice as likely to receive asset income as other races; 72 percent of elderly whites have asset income, compared to only 30 percent for blacks and 35 pecent of the elderly of Spanish origin.[9]

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[7] Two such surveys include the Survey of Changes in Family Finances [SCFF] commissioned by the Federal Reserve Board and the Department of Labor's Personal Consumption Expenditures Surveys [CES], which tend to confirm the rise and then fall of savings rates as individuals age. Wachtel, Paul. The Impact of Demographic Changes on Household Savings, 1950–2050. President's Commission on Pension Policy. Coming of Age: Toward a National Retirement Income Policy. Technical Appendix, Chapter 30. Washington, D.C., February 1981.

[8] Grad, Susan. Income and Resources of the Population 65 and Over, Social Security Administration, Office of Retirement and Survivors Insurance and Office of Policy. Govt. Print. Off., Washington, DC. Revised September 1986.

[9] Grad, Susan. Income of the Population 55 and Over, 1984. Social Security Administration, Office of Research, Statistics, and International Policy. Govt. Prin. Off., Washington, D.C. Revised December 1985.

Finally, the likelihood of asset income receipt is directly proportional to total income. Asset income is much more important to individuals with high levels of retirement income, however. Only 27 percent of aged units with income less than $5,000 receive income from assets at all, while 84 percent of those with incomes between $10,000 and $20,000 and 95 percent of those with income over $20,000 receive some asset income. One-third of aged units with incomes greater than $20,000 relied on assets to provide more than half of their retirement income, while only 11 percent of those with income less than $5,000 relied on assets for more than half their retirement income, and of these, most depended on assets to provide 100 percent of their retirement income.

Historically, income from savings and other assets has furnished a small but growing portion of total retirement income. Assets remain a far more important source of income for the retired population on the whole than pension annuities, largely because less than one in three retirees receive pension benefits.

2. ISSUES

The effort to increase national investment springs from a perception that governmental, institutional, and personal savings rates are lower than the level necessary to support a healthy economy. Except for a period during the World War II, when personal savings approached 25 percent of income, the personal savings rate in the United States has ranged between 5 and 8 percent of disposable income. Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families and work forces and efforts to maintain levels of consumption in the face of inflation. Personal savings rates in the United States have historically been substantially lower than in other industrialized countries. In some cases it is only one-half to one-third of the savings rates in European countries.[10]

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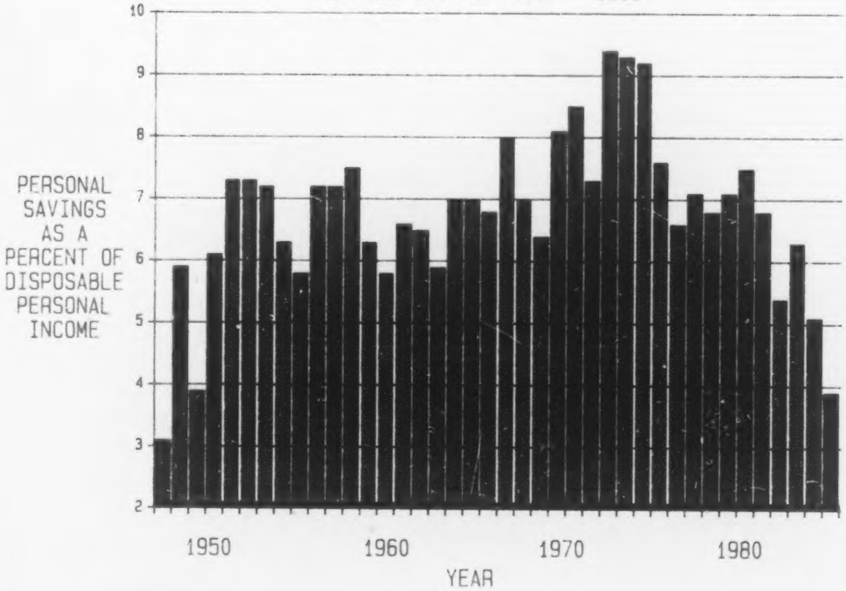
[10] U.S. Department of Commerce. International Economic Indicators, vol. VII, No. 4. Washington, D.C., December 1982.

CHART 3-1

PERSONAL SAVINGS RATE
UNITED STATES: 1947 - 1986



SOURCE: National Income Product Accounts, Bureau of Economic Analysis, Department of Commerce.

At the end of 1986 the Commerce Department released figures indicating that the personal savings rate for the third and fourth quarters of 1986 was at its lowest point since before 1950; 2.8 and 2.7 percent, respectively. Analysts suggested that without savings in corporate pensions, the country actually experienced a dis-savings overall. In part, this dramatically low figure may reflect an increase in the tendency to purchase goods on consumer credit. Given the additional expansion of tax incentives for retirement savings in recent years, the low rate of personal savings raises serious doubts about the effictiveness of those incentives. If retirement savings only take place in employer-sponsored plans, then policy analysts argue that retirement income goals might be better served by policies favoring these, rather than individual savings vehicles.

Even assuming present tax policy creates new presonal savings, critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute savings as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal savings being generated. Under this analysts, net national savings would be increased only when net new personal savings exeeded the Federal tax revenue forgone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of President's Commission on Pension Policy, issued in February 1981, recommended several steps to improve the adequacy of retirement savings including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for IRA's. In September of the same year, the Committee for Economic Development—and independent, nonprofit research and educational organization—issued its report entitled "Reforming Retirement Policies." The committee recommended a strategy to increase personal retirement savings which included tax-favored contributions by employees covered by pension plans to IRA's Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. In each Congress since the passage of the Employee Retirement Income Security Act [ERISA] in 1974 there have been expansions in tax-preferred savings devices. This was most obvious in the passage of ERTA in 1981. From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRA's, simplified employee pensions [SEP's], Keogh accounts and employee stock ownership plans [ESOP's]. ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined contribution plans.

The evolution of Congress' attitude expanded use of tax incentives to achieve socially desirable goals holds important implications for tax-favored retirement savings. When there is increasing competition for Federal "tax expenditures" the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

(A) INDIVIDUAL RETIREMENT ACCOUNTS [IRA'S]

Since the opportunity to save in IRA was extended to pension-covered workers by the Economic Recovery Tax Act of 1981 [ERTA], contributions to and assets held by IRA depositors have increased dramatically. IRA and Keogh deposits totaled $268.7 billion by the end of the first half of 1986, up from $198.6 billion in the same month of 1985, a 35.3-percent increase. ERTA broadened IRA eligibility so that individuals already participating in pension plans could contribute to an IRA as well. IRS date for 1982, the first year of universal IRA availability, recorded 12.1 million contributions to IRA's: nearly four times the number who contributed in 1981.[11]

IRA's constitute a major short-term revenue loss to the Federal Government, which may now equal as much as one-third the revenue loss attributable to "tax expenditures" on public and private employer pension plans. When ERTA was enacted in 1981, the Congress anticipated revenue losses due to IRA deposits of $0.98 billion for 1982 and $1.35 billion in 1983. The Treasury now estimates of actual revenue loss for those years was $4.8 and $10 billion respectively. Even if IRA contribution growth is now beginning to level off, the program is already much larger than Congress anticipated.

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[11] Employee Benefit Research Institute. EBRI Issue Brief No. 32, Individual Retirement Accounts: Characteristics and Policy Implications. Washington, DC, July 1984.

The rapid growth of IRA's poses a dilemma for employers as well as Federal retirement income policy. As IRA's come to play an increasingly important role in the retirement planning of employees, they may diminish the importance of the pension bond which links the interests of employers and employees. Employers may indeed face new problems in the attempting to provide retirement benefits to their work forces.

In recent years questions have been raised about the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional savings or does it merely redirect existing savings to a tax-favored account? Third, are IRA's retirement savings or are they tax-favored savings accounts used for other purposes before retirement?

Evidence suggests that those who use the IRA most might otherwise be expected to save without a tax benefit. Low-wage earners barely use IRA's. The participation rate among those with less than $20,000 income is two-fifths that of middle-income taxpayers ($20,000–$50,000 annual income) and one-fifth that of high-income taxpayers ($50,000 or more annual income). Younger wage earners, as a group, are also not spurred by the tax incentive to use IRA's. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.[12]

Though a low proportion of low-income taxpayers utilize IRA's relative to higher-income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers are apparently more often motivated to contribute to IRA's by a desire to reduce their tax liability than to save for retirement.[13]

One of the stated objectives in the creation of IRA's was to provide a tax incentive for increased savings among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive.

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[12] Ibid.

[13] Ibid.

As a matter of tax policy, IRA's may be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue is whether all IRA savings are in fact retirement savings or whether IRA's offer the opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited by the 10-percent penalty on withdrawals before age 50½ from taking savings out. However, those who do not intend to use the IRA to save for retirement can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA that occurs because the earnings are not taxed will surpass the value of the 10-percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings has emphasized the weakness of the penalty and promoted IRA's as short-term tax shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

An additional concern is that the IRA is not equally available to all taxpayers who might want to save for retirement. Currently, nonworking spouses of workers saving in an IRA may only contribute an additional $250 a year. Some contend that this creates an inequity between two-earner couples who can contribute $4,000 a year and one-earner couples who can only contribute $2,250 in the aggregate. They argue it arbitrarily reduces the retirement income of spouses, primarily women, who spend part or all of time out of the paid work force. Those who oppose liberalization of the contribution rules contend that any increase will primarily advantage middle and upper income taxpayers, since the small percentage of low-income taxpayers who do utilize IRA's often do not contribute the full $2,000 permitted them each year.

(B) EMPLOYEE STOCK OWNERSHIP PLANS [ESOP'S]

Employee stock ownership plans [ESOP's] have been promoted as a means for transferring the ownership of a company's capital to its workers. Although ESOP's can become a valuable source of retirement income to supplement Social Security, pension benefits, and personal savings, they are not designed (nor intended) to be an employees sole or primary retirement savings vehicles, or placement for traditional pension arrangements. Such plans can offer employees potential investment returns exceeding those of standard pension plans if the company is growing at a substantial rate or is consistently profitable, but at a considerably increased risk. Employees not only bear the risk of the plan's investment performance, but also bear the additional risk of relying on a nondivesified investment portfolio. Because the value of a company's shares can fluctuate over a wide range in response to the employer's fortunes, an ESOP cannot be considered a secure primary retirement vehicle for participants. Thus there has been considerable concern over recent action by some corporations which have terminated their defined-benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans is their expanding use in closely held corporations, where the value of the stock to employees is uncertain. For employees to have meaningful ownership interest in their employer through participation in an ESOP, the stock must be fairly valued and the employees must have some control over the way in which the stock is voted. But in a privately held corporation, one or both of these elements may be missing or constrained. It is difficult to value stock contributed to the ESOP of a privately owned corporation because there is no ready market for its resale. This creates an enormous potential for abuse. By overvaluing stock contributions an employer-owner can inflate the tax benefit received while employees may be hurt because the real value of the stock is less than its nominal worth.

Although Congress has clearly expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives which form the basis of congressional policy have been debated. In the case of ESOP's in closely held corporations with limited voting rights passthrough, the absence of voting rights and a ready market for resale cast doubt on the existence of any realistic incentive at all. Even in publicly traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulate fast enough compared to the total amount of stock outstanding to give employees any significant voice in corporate decisionmaking. As a result, several employee organizations have opposed the implementation of ESOP's unless coupled to representation on the employer's board of directors.

The ESOP concept has been supported by Congress in spite of these unresolved issues. It is important to note, however, that since an ESOP's value is inextricably tired to the financial health of the employer, their implementation should be traded off against current wages rather than retirement benefits when being used to save financially distressed employers. If an ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income as well. But by exchanging the ESOP for current wages an employee's retirement benefit remains insulated to some degree from the consequences of the employer's potential demise, while a much stronger link is forged between productivity incentives and the employee's present compensation.

The interests of older workers near retirement differ greatly from those of younger workers, such that an ESOP cannot be utilized as a replacement for traditional pension arrangements without having a differential effect on the interests of certain groups of employees.

2. LEGISLATION

(A) THE TAX REFORM ACT OF 1986 (PUBLIC LAW 99-514)

The dramatic changes to the individual income tax embodied in the Tax Reform Act of 1986 will have substantial and lasting effect on the structure of incentives for personal savings. The combination of lower tax rates and reduced deductions for retirement savings on the one hand, and the elimination of consumer credit interest deductibility on the other may, overall, have a dampening effect on personal savings. Among the provisions of the tax bill affecting individual savings for retirement, the most significant are the changes in the tax treatment of individual retirement accounts [IRA's]. In addition, the tax bill modified provisions affecting capital accumulation through employee stock ownership plans [ESOP's].

(1) Individual Retirement Accounts [IRA's]

Over the 2-year progression of the tax reform proposal, the fortunes of the IRA deduction swung radically from an expansion of the IRA deduction in the Treasury Department's original proposal to a restriction in the IRA deduction in the final bill signed by the President. The Treasury Department's November 1984 tax reform proposal called for an increase in the maximum deductible IRA contribution from $2,000 to $2,500 ($5,000 for a couple) and an increase in the deduction for IRA contributions by nonworking spouses from $250 to $2,500. The President's May 1985 tax reform proposal included the increase in the nonworking spouses deduction to the same level as the $2,000 deduction for workers, but did not increase the worker's deduction. In addition, the President's proposal reduced the amount of elective contributions permitted to employer-sponsored plans for actual contributions to an IRA.

Congress dropped proposals to expand the IRA deduction, and instead marked up provisions that would cut back on the IRA deduction for workers covered under an employer-sponsored pension. In general, these IRA provisions reflected the philosophy that Federal tax policy ought to apply an aggregate limit to voluntary savings for retirement and to provide more equal treatment between employees with no employer plan, and employees whose employers offer generous tax-favored savings opportunities. These provisions also had the effect, to a greater or lesser degree, of partially restoring the IRA to its pre-ERTA status, where employees covered by a pension plan were ineligible for IRA's. The House bill incorporated a provision to integrate the limits for contributions to an IRA along with salary reduction contributions to an employer-sponsored 401(k) plan. The bill would have limited salary reduction to $7,000 annually, and reduce the available contribution to an IRA dollar for dollar for contributions to a 401(k) plan.

The Senate bill took a different approach to limiting the IRA deduction. In concept, the Senate bill was a purer approach to tax reform in that it eliminated a larger number of deductions in an effort to reduce the number of tax brackets and lower the tax rates. The IRA deduction was viewed as a deduction that was not broadly used and was relatively inefficient in attaining the policy goal of building retirement income. To focus the deduction more effectively on those who needed it, the Senate eliminated the deduction for workers covered under an employer pension plan.

The final version of tax reform repeals the deductibility of contributions to an IRA for participants and the spouses of participants in pension plans with adjusted gross incomes in excess of $35,000 (individual) or $50,000 (family). Pension-covered workers and their spouses with AGI's between $25,000 and $35,000 (individual) or $40,000 and $50,000 (family) will have the amount of the maximum deductible IRA contribution reduced in relation to their incomes.

Workers in families without pensions, and pension-covered workers with AGI's below $25,000 (individual) and $40,000 (family) will retain the full deductibility of IRA contributions up to $2,000 per year. Even with the loss of the IRA deduction for some workers, however, all IRA accounts, even those receiving only after-tax contributions, will continue to accumulate earnings tax free.

(2) Employee Stock Ownership Plans

The Tax Reform Act of 1986 contains a mixed set of ESOP rule changes, generally intended to encourage the expansion of ESOP's and satisfy a few concerns about protection of participant's interests. First, the new rules make ESOP's more attractive for participants by allowing an election of partial diversification of the plan assets, and by shortening the period within which distributions to participants must be made. Second, the Tax Reform Act accelerated the repeal of the special payroll-based tax credit [PAYSOP] from 1988 to 1987. Third, the new rules expand other ESOP tax incentives.

Most of the ESOP's provisions adopted in the House-Senate Conference were based on the Senate bill. The approach to ESOP's taken in the House bill was radically different from that adopted in the Senate. The House bill was intended to eliminate the potential for discrimination in benefits, improve the delivery of benefits to participants, and broaden participation and control of existing ESOP's. Under the bill, additional qualification requirements would have been provided for ESOP's. These additional qualification requirements included: (a) Requiring more rapid (10-year graded) vesting; (b) modify, the ESOP nondiscrimination rules to limit the annual amount of employer contributions that may be allocated to employees who are officers, shareholders, or highly compensated; (c) expanding the pass-through voting requirements applicable to employer securities held by an ESOP; (d) permitting an eligible plan participant to direct the ESOP trustee to diversify a portion of the participant's ESOP account balance; and (e) modifying the distribution and put option requirements including the timing of the employer's payment of the put option price. The bill also repeals the special ESOP tax credit and deductions on dividends paid on employer securities, and certain other special provisions. The Ways and Means Committee indicated that cutbacks on certain tax benefits previously given to ESOP's was necessary in order to retain other more important incentives.

C. PROGNOSIS

The Tax Reform Act of 1986 reflects an effort to provide a fairer distribution of tax benefits—to equalize the tax payments of taxpayers with equal incomes. The intent of the tax reform initiative has been to redistribute the tax burden without adding any new benefits or losing revenue. By curbing or eliminating tax benefits for some individuals, it became possible to reduce rates overall, lessening the tax burden on individuals who have traditionally benefited little from deductions and exclusions.

The elderly as a group were largely unaffected by the changes made in the Tax Reform Act. Small percentages of the elderly were removed from the tax rolls, had tax payments reduced, or had their tax liability increase significantly. For the rest, the advantage of lower rates was largely offset by cutbacks in tax deductions, with no advantage resulting from the changes in the personal exemption that benefited younger taxpayers.

Deductions and tax deferrals to encourage the growth of retirement income and capital accumulation were brought under increased scrutiny during the consideration of the Tax Reform Act, and with the exception of the IRA deduction for some workers, were largely kept intact, or in the case of the ESOP expanded.

The thorough reevaluation of the tax code, long overdue, was completed in 1986. As a result, it is unlikely that significant income tax or savings incentives issues will be raised again by the Congress in the near future.

Chapter 4

EMPLOYMENT

OVERVIEW

For decades, employment and retirement policies in the United States have been directed toward encouraging early retirement. For example, Social Security was developed during the Great Depression, in part, to ease a sufficient number of older workers out of the labor force to make room for younger workers. Similarly, 9 out of 10 private pension plans offer financial incentives for early retirement; that is, prior to the normal retirement age (usually 65). When these programs are combined with employer administered mandatory retirement policies, a highly competitive work force, and rapidly changing technologies, it is not suprising that few older persons remain employed after their 65th birthday.

The statistics on older worker employment are startling. According to the Bureau of Labor Standards, the labor force participation of older men has been dropping dramatically during the last 30 years. Almost half of all men age 65 and over worked in 1950. By 1984, less than one-sixth (16.3 percent) were working. The early retirement trend has also extended down to the middle-aged as well. Since 1960, employment rates among men aged 55 to 64 have dropped by one-sixth, from 87 to 70 percent. Three-quarters of all new Social Security beneficiaries each year retire well before their 65th birthday, and most begin collecting benefits at age 63. A July 1985 General Accounting Office [GAO] study found that almost half of the individuals who receive private pensions, start receiving them by age 62, and almost 60 percent start receiving them before reaching 65. The increase in private pension receipt among persons under age 65 also reflects the trend toward earlier retirement. One study found that 67 percent of pension plan participants can retire with full benefits before age 65, up from 63 percent in 1983 and 1984.

This early retirement phenomenon raises serious policy concerns. First, the future economic security of older Americans is jeopardized by early labor force withdrawal. Those who do not work are three times more likely to fall below the poverty level. Second, earlier retirement contributes to the financial strain on Social Security and private pension plans. Third, serious shortages of skilled labor may develop in certain industries unless the early retirement trend is reversed. In contrast to these pressures to keep older persons in the labor force, however, it appears that labor demand is not sufficient to satisfy older persons' current employment needs. Therefore, the conflict between early retirement and the need to reverse the decline in labor force participation rates has become a major public policy dilemma.

In addition to the economic arguments for increasing the labor force participation rates among older workers, there are also compelling issues of civil rights involved. Age, like race, sex, religion, and national origin, is a protected category under Federal statutes. Eliminating age bias in the workplace is consistent with a tradition in America of struggle against arbitrary policies which discriminate against individuals because of their basic beliefs or their personal characteristics. The nearly unanimous opposition to mandatory retirement policies by the American public is one indicator of the strong sentiment against arbitrary age bias in employment. Yet, despite these civil rights arguments, the protections against age discrimination remain incomplete and somewhat ineffectual.

These twin problems—the early retirement trend and infringement on the civil rights of older workers—comprise the underpinnings of the public policy debate on employment for the aging. Steps have been taken in recent years to increase incentives for delayed retirement and to remove barriers to continued employment. During the 99th Congress legislators took a significant step forward by eliminating mandatory retirement for most Americans and by requiring continued pension accruals. Nonetheless, the trend toward earlier retirement continues and complaints of age discrimination in the work force are increasing.

A. BACKGROUND

1. Age Discrimination

Numerous obstacles to older worker employment exist in the labor force. These include: (1) Negative stereotypes about aging and productivity; (2) job demands and schedule constraints which are inconsistent with the skills and needs of older workers; and (3) policies which make it undersirable to remain in the labor force, such as early retirement incentives and, until recently, discontinued pension credits. Several of these have their roots in age discrimination.

Age discrimination in employment plays a pernicious role in blocking employment opportunities for older workers. It is not a new problem. The emergence of discriminatory employment practices for older workers can be traced to the late 1800's in the United States. There is some evidence that even in the late 1800's, negative attitudes about the capacities and productivity of the aged were already common throughout the Nation. The development of retirement as a social pattern in industry may have served to enhance and legitimize employment discrimination practices despite early evidence that older workers were capable, conscientious, and productive employees.

Today, age discrimination in employment is widespread. There is no agreement on the exact nature of the problem, nor is there a consensus on how to solve it. But few would disagree that the problem is real and that it affects the lives of millions of Americans. Despite Federal legislation to ban most forms of age discrimination from the workplace, most Americans believe age discrimination remains a serious problem. Two nationwide surveys by Louis Harris & Associates—one in 1975, the other in 1981—found nearly identical results; 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work."

The perception of widespread age discrimination held by the public is shared by a majority of business leaders. Most employers believe age discrimination exists, according to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc. The following key points summarize the survey's findings:

—61 percent of employers believe older workers today are discriminated against in the employment marketplace;

—22 percent claim it is unlikely that, without the present legal constraints, the company would hire someone over age 50 for a position other than senior management;

—20 percent admit that older workers (other than senior executives) have less of an opportunity for promotions or training; and

—12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

The pervasive belief that all abilities decline with age has fostered the myth that older workers are not as efficient as younger workers. This myth has no basis in fact. While it is clear that we have not yet succeeded in changing the attitude that older workers hinder management efforts to improve productivity, there is growing recognition of the value of older workers.

A study by Waldman and Avolio, published in the February 1985 issue of the Journal of Applied Psychology, revealed little support for the "somewhat widespread belief that job performance decline with age." The researchers found a strong correlation between performance improvements and increasing age, especially in objective measures of productivity. They found that "although chronological age may be a convenient means for estimating performance potential, it falls short in accounting for the wide range of individual differences in job performance for people at various ages."

Employers report that older workers stay on the job longer than younger workers. They are also perceived to offer experience, reliability, and loyalty. An AARP survey of 400 businesses in 1985 revealed that, in general, older workers are perceived very positively, and that they are particularly valued for their experience, knowledge, work habits, and attitudes. The survey showed that, contrary to popular belief, employers give older workers their highest marks for productivity, as well as for attendance, commitment to quality, and satisfactory work performance. A surprising 90 percent believe that older workers are cost-effective and the overwhelming majority believe that the cost of older workers is justified when their value to the company is considered.

Corporate age discrimination can result in loss of valuable experience, mature judgment, and priceless know-how. Attitudes toward older workers are changing, but as the rise in the number of Age Discrimination in Employment Act [ADEA] charges filed attests, much more must be done to provide fair opportunities in employment and retirement for older workers.

The forms of age discrimination range from the more obvious mandatory retirement ages, to more subtle job harassment and early retirement incentives. Each of these represent not only a threat to the well-being of older individuals, but also undermine the economic stability of the Nation's retirement income systems and, to a lesser extent, the larger economy as well. While the number of people getting maximum Social Security benefits is increasing, most retirees get less than the maximum. Census Bureau data for 1985 shows that of the 26 million people aged 65 and over in that year, over 17 million had an annual income of less than $10,000 from all sources. The average annual Social Security benefit paid to a couple is $9,768, less than $4,000 above the official poverty level income for an elderly couple. Only slightly more than half of Americans currently in the work force are covered by a private pension plan and most people 65 and over do not have substantial holdings in savings, stocks, insurance policies, and bonds.

According to a 1986 report of the National Commission for Employment Policy [NCEP], several million older workers suffered severe labor market problems (low income and unemployment or underemployment) in 1980. Unemployment is a particularly serious problem for those elderly persons who have to work for economic reasons or who desire to stay active. In 1984, the unemployment rate for the elderly was 3.3 percent. Of Americans age 60 and over, 315,000 were out of work in 1984; 97,000 of of these were age 65 or over. These numbers are not large when compared to youngar age groups, but because duration of unemployment is longer among older workers and discouraged older workers are not included in these statistics, the official unemployment rate is not an accurate indicator of the seriousness of the problems.

Older workers who have lost their jobs have more difficulty in obtaining other jobs and stay out of work longer than younger persons. In fact, persons age 55 to 64 have the longest speils of unemployment of any group in the country. Unemployed individuals aged 55 to 64 had an average of 26.2 weeks of unemployment in 1984, as compared to 16 weeks for workers age 20 to 24.

According to the Bureau of Labor Standards, because an older worker is likely to be unemployed for a longer period than a younger employee, he or she is also more likely to exhaust available unemployment insurance benefits, thereby suffering economic hardships. Additionally, the Employment and Training Report of the President (1978) states that the problems of older unemployed workers are worsened by the fact that many persons over 45 may still have significant financial obligations.

Discouraged workers are those who report that they want a job but are not looking because they believe that they cannot find one. There is evidence that the longer periods of unemployment experienced by older workers often lead to early involuntary retirement as they quit searching for employment and become discouraged workers. Older workers disproportionately experience labor market discouragement. For men age 65 and over, the annual average level of discouraged workers is almost as large as the number of unemployed. The BLS reports that the prospects of an older male worker finding work are so low that he is three times more likely to become discouraged and withdraw from the work force than younger workers.

When older workers are fortunate enough to find work, they generally face a cut in earnings in a new job and suffer a decline in status compared to their previous employment. Following retirement, many people experience financial difficulties because of decreased income which often accompanies retirement, difficulty in finding reemployment, longer life spans, erosion of fixed pensions by inflation, and reduced private pension benefits as a result of forced retirement.

Finally, medical evidence suggests that mandatory retirement can have a detrimental effect on a person's physical, emotional, and psychological health. It may even affect his or her life span. According to the American Association of Retired Persons, people who retire unwillingly don't fare so well—30 percent of the country's retirees are believed to suffer serious adjustment problems. Psychologists report that older workers face wrenching psychological stress—their hopes are shattered, they are depressed, and frustrated.

Thus, age discrimination reduces the work efforts of older people, encourages premature labor force withdrawal, and increases the load on an already burdened Social Security system and on private pensions. Without adequate solutions to the problems of age discrimination and without incentives to encourage more older workers to remain employed longer, the Nation could be facing a serious economic as well as social crisis in the future.

(A) THE AGE DISCRIMINATION IN EMPLOYMENT ACT

In order to encourage equal employment opportunities for older persons, Congress enacted the Age Discrimination in Employment Act [ADEA] in 1967, which became effective on June 12, 1968 (Public Law 90-202). The ADEA legislation was the culmination of years of debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the competing interests of the right of the older worker to be free from age discrimination in all aspects of employment, and the employer's preogative to control the managerial decisions which make a business profitable. The provisions of the ADEA attempt to balance these competing interests by prohibiting age discrimination based upon an employer's arbitrary policies which would prevent employment of individuals above a certain age. Arbitrary age limits may not be used as conclusive determinations of nonemployability, so that employment decisions regarding older persons should be based on an individual assessment of each applicant's or employee's potential or ability.

Specifically, the Age Discrimination in Employment Act was enacted "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment, and to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act originally prohibited employment discrimination against persons aged 40 to 65. The upper age limit was set at 65 because it was the common retirement age in U.S. industry and the normal eligibility age for full Social Security benefits. In 1978, the act was amended to protect persons up to age 70. There age limits were chosen to focus coverage on workers especially likely to experience job discrimination. As will be seen, the Age Discrimination in Employment Act Amendments of 1986, removed the age 70 cap and all persons over the age of 40 are not protected under the law.

The age specifies that actions otherwise deemed unlawful may be permitted if they are based upon the following considerations:

—Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business;

—Where differentiation is based on reasonable factors other than age (for example, the use of physical examinations relating to minimum standards reasonably necessary for specific work to be performed on a job);

—To observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority system or benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and

—Where an employee is discharged for good cause.

In addition, an executive or high-ranking, policymaking employee in the private sector entitled to annual private retirement benefits of at least $44,000 could be compulsorily retired at age 65, simply because of age. This is known as the "executive exemption" and it was designed to allow turnover at the top levels of the organization. While is has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

The ADEA has been amended a number of times since it's enactment in 1967. The first set of amendments occurred in 1974, when the provisions of the act were extended to include Federal, State, and local government employers. Also, the number of workers covered was increased by exempting only those employers who have fewer than 20 employees. Previous law exempted employers with 25 or fewer employees. In 1978, the act was amended to extend protection to age 70 for private sector, State, and local government employers, and by removing the upper age limit for employees of the Federal Government. Regulations implementing the 1978 amendments, however, specified that employers are not required to credit years of service worked beyond age 65 to final pension benefit levels. As discussed below, in 1986, the ADEA was amended to require post age 65 pension accruals.

The act was amended in 1982 by a provision included in the Tax Equity and Fiscal Responsibility Act [TEFRA]. This provision, referred to as the "working aged" clause, requires employers to retain their over-65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. Now, the situation is reversed, with Medicare acting as the payer of last resort. This provision was designed to be a costsaver for the Medicare Program, but it is viewed as a new obstacle to employment for older workers because it increases the costs of employment and, for many small companies, there are serious problems in finding insurance coverage at all for these older workers.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act. Public Law 98-459, section 11(f), amended the ADEA by extending protections to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation was based in part on the belief that many such workers are really an extension of the U.S. work force who should not be subject to possible age discrimination just because they are assigned abroad. Section 12(c)(1) of the ADEA, the executive exemption, was also amended by raising, from $27,000 to $44,000, the annual private retirement benefit level for determination of exemption from provisions of the act for persons in bona fide executive or high policymaking positions. As will be discussed in detail below, major amendments to the act were enacted in 1986, during the final days of the 99th Congress.

(B) THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

The Equal Employment Opportunity Commission [EEOC], which enforces the laws prohibiting discrimination has reported a 100-percent increase in age-related claims since 1971. During fiscal year 1986, the EEOC filed 118 lawsuits under the ADEA, an increase of more than 20 percent over the 96 suits filed by the Government in any 1-year period since the ADEA was enacted. While the number of lawsuits filed has increased, critics complain that the EEOC is moving away from broad complaints against big companies and entire industries in favor of more tightly focused cases involving specific persons.

It appears that age discrimination complaints will only continue to rise. In 1980, one-fifth of the U.S. population was over 55 years old. Demographic statistics project that this figure will climb to approximately 25 percent by the year 2000. While the total U.S. population is expected to increase by one-third between 1982 and 2050, the older population (aged 55 and older) is expected to increase 113 percent. Eventually, this demographic trend is expected to mature the U.S. workforce and will mean greater competition among older and middle-age workers.

In the early eighties, the recession caused employers to search for easy ways to reduce their payrolls and to bring in younger, less expensive workers. In firms where younger workers were already laid off, further reductions had to come from older workers. Plant closings have also resulted in large numbers of displaced older workers. In addition, companies anxious to accommodate the baby boom generation will come under increasing pressure to find vacancies for them. The House Select Committee on Aging has estimated that the elimination of mandatory retirement would add about 840,000 workers age 70 and over to the 28 million workers aged 40 to 70. This would be a 3 percent increase in the number of individuals protected against age discrimination in employment and may also contribute to a greater caseload at the EEOC.

2. FEDERAL PROGRAMS

A second thrust of the Federal Government is to provide funds for training disadvantaged and dislocated workers to assist them in becoming more employable. This section describes two Federal programs designed to promote the employment opportunities of older workers: The Job Training Partnership Act [JTPA] Program and the Community Service Employment Program under title V of the Older Americans Act.

(A) THE JOB TRAINING PARTNERSHIP ACT

The new Job Training Partnership Act [JTPA], enacted by the 97th Congress, and which went into effect October 1, 1983, establishes a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. For program year 1985, which began July 1 and ran through June 30, 1986, slightly more than $3.6 billion was appropriated for JTPA programs as part of the fiscal year 1985 Appropriations Act (Public Law 98-619). The fiscal year 1986 appropriations (Public Law 99-178) contained $3.4 billion for JTPA.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the title II-A program, which authorizes training for disadvantaged adults and youth, funds are allotted among States according to the following three equally weighted factors: Number of unemployed individuals living in areas with jobless rates of at least 6.5 percent for the previous year; number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and the number of economically disadvantaged individuals. Training under title II-A can include on-job-training, classroom training, remedial education, employability development, and a limited amount of work experience. For the period July 1, 1985, through June 30, 1986, about 11,888 persons 55 and older participated in the title II-A program, representing 3 percent of total participants.

Section 124(a-d) of JTPA also establishes a statewide program of job training and placement for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their title II-A allotments for this older workers program. During the current program year, from July 1, 1985, to June 30, 1986, the older workers' setaside was funded at $57 million. This level was maintained for the 1986 program year. The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns. At the time of this writing, the Department of Labor had not yet released the program year 1986 data on the 3 percent setaside of the title II-A allotments.

For workers who have been or are about to be laid off, are eligible for or have exhausted their entitlement to unemployment compensation, and are unlikely to return to their previous occupation or industry, Congress created title III. The dislocated workers program is administered by the States and includes such services as job search assistance, job development, training in job skills for which demand exceeds supply, relocation assistance and activities conducted with employers or labor unions to provide early intervention in case of a plant closing. During the period between July 1, 1985, and June 30, 1986, about 9,000 persons 55 and over had been served by the title III program (about 8 percent of total program terminations).

According to the final draft of recommendations to be released in 1987 on job training, the JTPA is working well and, with minor exceptions, is meeting its legislative mandate. The report, to be issued by the National Commission for Employment Policy [NCEP], an independent Federal Government panel appointed by the President, however, was criticized as glossing over many of its problems. The report did acknowledge that conversations with State Job Training Coordination Council chairs confirmed that some States are having difficulty using the 3 percent setaisde funds for older workers due to recruitment problems and difficulty in placing this population. In testimony presented to Congress, the NCEP recommended increased funding for JTPA because the current programs can aid less than 10 percent of all eligible low-income persons and dislocated workers, including older workers.

While the impact of JTPA on mature and older workers is probably minimal, the need for and importance of JTPA is underscored by a November 1984 Department of Labor study on displaced workers. According to the study, 5.1 million workers lost their jobs due to the decline of an industry or a plant closing between 1979 and 1984. The chance of reemployment for these displaced workers declined significantly with age. Only 41 percent of those between 55 and 64 were able to reenter the labor force in any capacity (as compared to 70 percent for those between the ages of 20 and 24). Only 21 percent of those over 65 became reemployed and of those who found a job, almost half (45 percent) received lower pay than at their previous position and one-third took salary cuts of more than 20 percent. The study showed that the older an individual was when he lost his job, the longer he would be unemployed and the more likely he would become completely discouraged and drop out of the labor force altogether. Overall, there are more than 1.2 million discouraged workers in the Nation.

(B) TITLE V OF THE OLDER AMERICANS ACT

The Community Service Employment Program for Older Americans was given statutory life under title IX of the "Older Americans Comprehensive Services Amendments of 1973." Its purpose is "to promote useful part-time opportunities in community service activities for unemployed low income persons." Amendments passed in 1978 redesignated the program as title V of the Older Americans Act and it was reauthorized through fiscal year 1987 by Public Law 98-549, the "Older Americans Act Amendments of 1984," enacted on October 9, 1984. The program responds to certain identified needs of older persons by providing opportunities for part-time employment and income. It also serves as a source of labor for various community service activities. The program can also assist unemployed older persons move into permanent unsubsidized employment.

The program is administered by the Department of Labor [DOL], which awards funds to national sponsoring organizations and to

State agencies. Persons eligible under the program are those who are 55 years of age and older (with priority given to persons 60 years and older), who are unemployed, and whose income level is not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services. Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is less. Federal funds may be used to compensate participants for up to $13,000 of work per year, including orientation and training. Participants work an average of 20-25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

In recent years, the Reagan Administration has made a number of proposals which would have significantly altered the Older Americans Act's employment focus. These have ranged from proposals to completely eliminate the title V program to proposals to change the administrative and program structure by transferring all or a portion of the program from the Department of Labor to the Department of Health and Human Services, and to replace the subsidized job concept with one which would assist older persons to create their own business. All of these proposals were ultimately rejected by Congress which has supported the title V program in its current form and which has voted for program expansion by increasing appropriations 22 percent from its 1980 level. In its fiscal year 1986 budget submission, the administration made no recommendations for changes in the existing structure of the program.

SCSEP is one of the few remaining direct job creation programs since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment Programs. The program has seen steady increases in funding and participant enrollment since its inception. In the 1968-69 program year, the first full year of its operation in a form similar to the current program, participant enrollment was 2,400 with a budget of $5.5 million. In program year July 1, 1985, to June 30, 1986, title V funding appropriations are $326 million (representing about 28 percent of total funds appropriated under the Older Americans Act of 1965) and funding about 63,700 positions. Nearly 80 percent of the participants are age 60 or older, and nearly half are age 65 or older. Over 60 percent are females, half have not completed high school, and over 85 percent have a family income below the poverty line.

Although the program supports a relatively small number of jobs—63,000 authorized positions and 13,445 unsubsidized placements in the 1985-86 program year—it is the most visible federally supported employment programs for older persons. Evaluations and program reviews conducted on the program in recent years have generally proven positive.

In fiscal year 1986, three reports were issued on a 1-year evaluation of SCSEP. One report provided information on four additional mechanisms whose use would tend to increase community service employment opportunities. A second report analyzed the success of the regular SCSEP program in fostering useful, part-time community service activities for the target population. The third report compared the experimental SCSEP projects with the regular SCSEP in regard to demographic characteristics, training provided, and levels of post-program unsubsidized employment. Two other reports were also issued on studies of the older Men's Cohort of the National Longitudinal Surveys of labor market experience. One of these reports analyzed the interrelationships of health factors and job satisfaction with work activities, while the other compared the accuracy of two methods of predicting retirement behavior.

B. ISSUES

1. MANDATORY RETIREMENT

Currently, there are 1.1 million Americans age 70 and over in our work force. Many of these people want to continue working—sometimes for reasons of self-fulfillment, but more often for reasons of economic necessity. Until recently, Federal law deprived these people of the same guarantees of equal opportunity in employment that other citizens enjoy.

The most clearcut form of age discrimination is mandatory retirement rules. According to a recent Department of Labor study, 51 percent of the Nation's work force faced an arbitrary mandatory retirement age in 1980, usually age 70, while 45 percent faced no mandatory retirement age. Mandatory retirement rules persisted for a variety of reasons. Many employers perceive older workers as a group to be ill-suited for certain jobs because of declining mental and physical capacity, an inability to learn, a lack of creativity, and inflexibility. Vast amounts of research on the abilities of older workers, however, consistently refute these employer-held stereotypes.

Organizations for the aged and others in favor of eliminating mandatory retirement argue that judging a person's qualification for a job solely on the basis of age, without regard to fitness for a job, is inequitable and that chronological age alone is a poor predictor of ability to perform a job. Other arguments for eliminating mandatory retirement include: (1) Older workers discriminated against may lose income; (2) the loss of status associated with the loss of a job may result in the deterioration of mental and physical health for the older person; (3) the loss of skills and experience from the work force due to mandatory retirement results in a loss to our Nation's productivity and gross national product (GNP); and (4) allowing workers to stay on their jobs longer helps the financial status of the Social Security and other retirement systems because payment of full retirement benefits is deferred until a later age and continued contributions will flow into these programs.

Employers and others in favor of retaining mandatory retirement note that older persons, as a group, may be less well-suited for some jobs than younger workers because declining physical and mental capacity are found in greater proportion among older persons and because they do not learn new skills as easily as younger persons. Other arguments against eliminating mandatory retirement include: (1) Mandatory retirement preserves the dignity of the older worker who is no longer capable of performing his or her job adequately, and who would otherwise be singled out for discharge in a personally damaging proceeding; (2) mandatory retirement provides a predictable situation allowing both management and employees to plan for the future; (3) older workers can often retire with Social Security or other retirement income, making jobs (and promotions) available to younger workers who do not have other income potential; and (4) by opening up jobs, mandatory retirement also provides more opportunities to women and minorities who are underrepresented in certain occupations.

In response to the argument that eliminating mandatory retirement entirely would unfairly prevent younger people from moving up the ladder, a DOL study has shown that abolishing mandatory retirement would not result in displacing women and members of racial minorities. The Labor Department found that the rise in permissible mandatory retirement age to 70 resulted in only negligible effects on women, minorities, and youth, and that abolishing mandatory retirement would have a similarly minimal impact. The Labor Department studies refuted the idea that an increased number of older workers would significantly delay promotions for younger workers. One study reported by the House Select Committee on Aging states that a 10-percent increase in the labor force participation rates of men age 65 and over would delay, on average, promotions at the highest ranks by only one-half year, while at the lower ranks, individual promotions would be retarded by approximately 5 to 10 weeks. Similarly, simulations conducted by the Urban Institute suggest that the fear that eliminating the mandatory retirement age altogether would seriously affect job opportunities for younger workers is unfounded.

The Reagan administration's support for legislation to abolish mandatory retirement has been inconsistent. In April 1982, the President endorsed the elimination of mandatory retirement, saying, "I will back legislation while eliminating mandatory retirement requirements in government and private industry based solely on age."

Soon after that statement was made, however, administration officials stated before congressional committees that the President supported removal of the upper are limit only for forced retirement, but that other aspects of employment, such as hiring and promotions, could be subject to age 70 limits.

The administration took this position, in part, because it believes that when individuals are hired or promoted to new responsibility, companies very frequently make investments in them which they expect to be amortized over a longer period of time. Up until the last hours before final passage of legislation eliminating mandatory retirement in the 99th Congress, the administration gave only lukewarm support to it.

2. ADEA ENFORCEMENT PROCEDURES

Some employers and their representatives have argued that title VII of the Civil Rights Act—which prohibits employment discrimination on the basis of race, color, sex, religion, or national origin—does not allow jury trials or liquidated damage awards. Age discrimination cases, they argue, should not be treated differently.

Others contend that to argue that the ADEA should parallel title VII in all respects ignores important procedural and substantive differences between the statutes, of which Congress was cognizant when it passed the ADEA in 1967. A complex set of arguments underlies these issues and they are very important to a full understanding of the ADEA.

(A) JURY TRIALS

Section 7 of the ADEA specifically incorporates the enforcement scheme used in employee actions against private employers under the Fair Labor Standards Act [FLSA]. In *Lorillard* v. *Pons,* the Supreme Court found that the incorporation of the FLSA scheme into section 7 of the ADEA indicated that the FLSA right to trial by jury should also be incorporated in the ADEA.

The *Lorillard* holding was codified in 1978 when section 7(c) of the ADEA was amended to provide expressly for jury trials in actions brought under that section. Thus, 1978 amendments confer a right to a jury trial and the legislative history indicates that it was viewed as an important incentive for voluntary compliance.

Those opposed to jury trials in ADEA cases believe that litigating an age claim before a jury decreases an employer's chances because juries tend to concern themselves only with whether the employer's actions are fair as opposed to nondiscriminatory. They also believe that juries tend to sympathize with the plight of aging plainstiffs and make unreasonably large awards against private business. Those who support doing away with jury trials suggest that they "tie up" the courts. Finally, they claim that ADEA cases raise complex legal and factual issues that are difficult for juries to determine.

Those opposed to elimination of jury trials in ADEA cases argue that the right to a jury trial has deep rooted historical and constitutional dimensions and the right to trial by jury is considered to be precious by all who revere the American legal tradition. They believe that judges may be too removed from the usual employer-employee relationship or too protected from age discrimination by lifetime appointments to be understanding of the issues raised by individuals who have been discriminated against on the basis of age.

Supporters of keeping jury trials in ADEA cases believe that the central issue in an ADEA case—whether the employer intentionally discriminated on the basis of age—is precisely the type of factual question that juries are equipped to handle. Nor do they think that ADEA cases are more complex than the other types of jury cases, such as securities or antitrust cases, involving complex legal and technical issues. Supporters of jury trials concede that the courts are "tied up," but they refute the notion that it is the fault of ADEA plaintiffs who demand juries. They note that defendants also contribute to "tying up the courts" in ADEA cases by filing costly and time-consuming motions to prevent the case from going to the jury.

Finally, they argue that there is no clear cut evidence that juries are more sympathetic to aggrieved older workers than are judges. They cite a study by Barbara Fosberg, in which 239 ADEA cases were analyzed, and which indicates that jury verdicts show no bias toward plaintiffs. A 1984 analysis of age cases by Shuster and Miller similarly reveals that employers are victories in 63 percent of the ADEA actions and that plaintiffs have seen their pre-1979 rate of success (33 percent) only slightly improved since 1979, limiting the impact of the 1978 jury trial amendment.

(B) LIQUIDATED DAMAGES

The ADEA incorporated some portions of the FLSA to provide that a prevailing plaintiff is entitled to liquidated damages where the employer has wilfully violated the act. The legislative history indicates that the ADEA imposes double damages to provide an effective deterrent to willful violations. Liquidated damages decrease and deter future violations by encouraging employers to enforce the act.

As previously mentioned, employer groups opposed to the liquidated damages provision question why white collar male employees should receive double damages under the ADEA while minorities and women do not receive them under title VII. Employers complain that the standard of willfullness is so low that liquidated damages are routinely awarded in ADEA litigation and that age cases often result in a windfall to plaintiffs. They also claim that verdicts complicate the settlement process and encourage the filing of age claims that have questionable merit.

Supports of the liquidated damages provision note that no punitive damages or damages for pain and suffering are recoverable under the ADEA and that a plaintiff is limited to damages measured by lost earnings and an additional equal amount as liquidated damages where applicable. Thus, liquidated damages operate, in effect, as a substitute for punitive damages. They further note that while judges have the authority to put the victim of age discrimination back into the position he would have been in but for the unlawful discrimination, it is often inappropriate or impossible to do so. The job may no longer exist or it may be unavailable. A high degree of animosity, hostility, or antagonism may exist between the employer and employee, making a productive and amicable working relationship impossible. Reinstatement may also be inappropriate where it would require displacing another person from the plaintiff's former job. Thus, liquidated damages are important because judges are often reluctant to order job reinstatement or monetary awards beyond the date of the decision, even though the plaintiff may continue to experience problems securing appropriate employment.

Supporters also cite a recent ruling by the Supreme Court in *Trans World Airlines* v. *Thurston*, which adopted a single, tightened standard in deciding ADEA liquidated damages claims. The Court held that to find willfullness, the judge or jury must decide that the employer knew that its conduct violated the act, or, in commiting the discriminatory action, that the employer showed reckless disregard for whether its conduct was prohibited by the act.

(C) WAIVER OF RIGHTS UNDER ADEA

As previously mentioned, Congress incorporated the enforcement provisions of the Fair Labor Standards Act [FLSA] into the ADEA. Section 7(b) of the act, specifically incorporates the enforcement standards of the FLSA. In addition, the Supreme Court has held that not only the FLSA enforcement provisions, but also the pre-ADEA case law dealing with enforcement of FLSA rights, were incorporated into the ADEA section 7 enforcement provision. See *Lorillard* v. *Pons,* 434 U.S. 575 (1978). Under the pre-ADEA caselaw dealing with contractual waivers of private rights under the FLSA, there were two Supreme Court cases which, taken together, may be interpreted to hold that FLSA rights cannot be privately waived. It would follow, then, that under the ADEA enforcement scheme nonsupervised private agreements to waive ADEA rights would also be impermissible.

In *Runyan* v. *National Cash Register Corp.* (CA6, No. 83-3862, April 7, 1986), however, a private release form purporting to waive all claims against an employer was held by the full bench of the U.S. Court of Appeals to be binding under the ADEA. By a vote of 11 to 12, the Court rejected the argument that an unsupervised private release of rights under ADEA is void as a matter of law. The Court's holding was limited to the circumstances of the case where nothing indicated that the employer had exploited its superior bargaining power by forcing the employee to accept an unfair settlement. Indeed, it is interesting to note that the plaintiff in the case was an attorney at the NCR Corp. and was an expert in labor relations law.

3. Mandatory Retirement for Tenured Faculty

A debate rages over whether the uniqueness of the tenure system in institutions of higher education should earn it special treatment under the law and whether the mandatory retirement of tenured faculty serves the national interest.

Most agree that the tenure system is different from many other employment situations. Tenure protects academic freedom by prohibiting dismissals except under specific conditions. Many administrators suggest that without a defined end to this employment, through the tenure contract and by way of the mandatory retirement age, educational institutions would be forced to end the tenure system and these protections to academic freedom and excellence.

The argument has been made that without mandatory retirement at age 70 institutions of higher education will not be able to continue to bring in "fresh blood" or the intellectual surge needed to maintain excellence. It is argued that planning for the institution and its faculty needs would be undermined by the increase in otherwise retired faculty which would occur if the age 70 cap were to be lifted. The older faculty, it is claimed, would prohibit the institution from hiring younger teachers who, with their current state of knowledge, are better equipped to serve the needs of the school. The argument continues that allowing older faculty to teach or research past the age of 70 denies the already limited number of positions to women and minorities.

Proponents of an exemption cite a study by the DOL that the salaries of faculty nearing retirement are about twice those of newly hired faculty. Accordingly, prohibiting mandatory retirement might also exacerbate the financial problems colleges and universities are facing because of the reductions in public funds.

Those who oppose the exemption believe that there are not sufficient reasons to single out faculty for special, discriminatory treatment. They call it double discrimination—once on the basis of age and again on the basis of occupation. Opponents of the exemption argue that colleges and universities are using mandatory retirement as a way to rid themselves of unproductive professors, instead of dealing directly with a problem that can afflict faculty members of any age. They argue that the use of performance appraisals are a better criterion for ending teaching service than age. They claim that there is no evidence that many professors would stay past 70 even if they could, and that predictions of dire consequences from uncapping the retirement age may be exaggerated. According to the Teachers Insurance Annuity Association and College Retirement Equities Fund, the average age at which faculty members begin collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

Opponents of the exemption claim that there is little statistical proof that older faculty keep minorities and women from acquiring faculty positions. Indeed, they cite statistical information gathered at Stanford University and analyzed in a paper by Allen Calvin which suggests that even with mandatory retirement and initiatives to hire more minorities and women, there was only a slight change in the percentage of minority and women faculty on the tenure track and holding tenured faculty positions, but there is no definitive link to keeping older faculty employed.

4. Exemption for State and Local Public Safety Officers

As earlier noted, the ADEA allows an exception against age discrimination in the workplace where "age is a bona fide occupational qualification reasonably necessary to the normal operation of a particular business, or where the differentiation is based on reasonable factors other than age." The "BFOQ" defense has been most successful in cases that involve the public safety. In general, courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters because the safety of the public was at stake. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, on March 2, 1983, in *EEOC* v. *Wyoming*, determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is a bona fide occupational qualification [BFOQ] for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress' commerce powers—an argument not sustained by the Court.

In addition, in June 1985, the Supreme Court rendered two decisions in cases arising under the ADEA favorable to employees who had challenged the mandatory retirement policies of their employers. The first case, *Johnson* v. *Mayor and City Council of Baltimore,* Nos. 84-518 and 84-710 (June 18, 1985), involved six firefighters who challenged the city of Baltimore's municipal code provision that established a mandatory retirement age at 55 for firefighters. The Court of Appeals, accepting the city's argument, had held that the Federal civil service statute, which requires most Federal firefighters to retire at age 55, constituted a bona fide occupational qualification [BFOQ] for the position of firefighters employed by the city. The Supreme Court reversed this decision, stating that nothing in the *Wyoming* decision or ADEA warrants the conclusion that a Federal rule, not found in the ADEA, and by its terms applicable only to Federal employees, necessarily authorizes a State or local government to maintain a mandatory retirement age as a matter of law. The Court found that it was Congress' indisputable intent to permit deviations from the mandate of the ADEA only in light of a particularized, factual showing. The Court concluded that Congress' decision to retire certain Federal employees at an early age was not based on a BFOQ, but instead dealt with "idiosyncratic" problems of Federal employees in the Federal civil service. Accordingly, the Court ruled that State or private employer cannot look to exemptions under Federal law as dispositive of BFOQ exemptions under the ADEA. There is a need, the Court said, to consider the actual tasks of the employees and the circumstances of employment to determine when to impose a mandatory retirement age.

The second case, *Western Airlines, Inc.* v. *Criswell,* No. 84-127 (June 18, 1985), raised a challenge under the ADEA to Western Airline's requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and copilot become incapacitated, were subject to mandatory retirement at age 60. The Supreme Court upheld a jury verdict for the plaintiffs against an airline defense that the age 60 requirement constituted a BFOQ. The Court confirmed that the BFOQ defense is available only if it is reasonably necessary to the normal operation or essence of a defendant's business. The Court also noted that an employer could establish this defense only by proving that substantially all persons over an age limit would be unable to perform safely and efficiently the duties of the job, or that it would be impossible or highly impractical to deal with older employees on an individualized basis.

In both of these cases, a unanimous Court seemed to be looking very critically upon attempts to expand the BFOQ defense beyond specific high risk occupations. The Court also stressed the relationship between individual performance and employment in a particular task, rather than reliance on a standard of chronological age disqualification. Thus, by adopting a very narrow reading of the BFOQ exemption, the Court appears to have strongly endorsed individualized determinations.

Many States and localities have mandatory retirement age policies below age 70 for public safety officers and they were concerned about the impact these decisions will have. As of March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement or minimum hiring age laws. As a result, legislative proposals were made in Congress to exempt public safety officers from some or all of the ADEA provisions.

Supporters of such legislation argue that the mental and physical demands, and safety considerations for the public, the individual, and coworkers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Sponsors of the legislation believe that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA because of conflicting court decisions; and even if possible, would require costly and time consuming litigation. They note that jurisdictions wishing to retain the hiring and retirement standards that they established for public safety officers prior to the Wyoming decisions are forced to engage in costly medical studies to support their standards.

Supporters of an exemption question the feasibility of individual employee evaluations and some have cited the difficulty involved in administering the tests because of technological limitations concerning what human characteristics can be reliably evaluated, the equivocal nature of test results, and economic costs. They do not believe that individualized testing is a safe and reliable substitute for pre-established age limits for public safety officers.

Many believe that there is no justification for applying one standard to Federal public safety personnel and another to State and local public safety personnel. They believe that exempting State and local governments from the hiring and retirement provisions of the ADEA in their employment of public safety officers will give them the same flexibility that Congress granted Federal agencies which employ law enforcement officers and firefighters.

Those opposed to exempting safety officers from the ADEA note that age affects each individual differently, and they say that there are tests that can be used to measure the effects of age on individuals, including those that measure general fitness, cardiovascular condition, and reaction time. They cite research on the performance of older law enforcement officers and firefighters which supports the conclusion that job performance does not invariably decline with age and research shows that there are accurate and economical ways to test physical fitness and predict levels of performance for public safety occupations. All that the ADEA requires, they say, is that the employer make individualized assessments where it is possible and practical to do so. The only fair way to determine who is physically qualified to perform police and fire work is to test ability and fitness.

Those arguing against an exemption state that mandatory retirement and hiring age limits for public safety officers are repugnant to the letter and spirit of the ADEA, which was enacted to promote employment of older persons based on their ability rather than age and to prohibit arbitrary age discrimination in employment. They believe that it was Congress' intention that age should not be used as the principal determinant of an individual's ability to perform a job, but that this determination, to the greatest extent feasible, should be made on an individual basis. They contend that maximum hiring age limitations and mandatory retirement ages are based on notions of age-based incapacity and would represent a significant step backward for older working Americans.

5. PENSION ACCRUALS

Under an interpretation of the 1978 amendments to the Age Discrimination in Employment Act, pension plans regulated under the Employee Retirement Income Security Act [ERISA] are not required to continue accrual of pension credits for employees who work beyond normal retirement age. Under a mandatory retirement age of 70, it is estimated that continued accrual of pension credits would result in an estimated 50,000 more workers age 60 to 70 in the labor force by the year 2000. If the age 70 limit was removed as well, a total of 68,000 more men age 60 to 70 probably would be in the work force by that year. These statistics suggest that the discontinuation of pension benefit accruals are a modest disincentive for continued employment beyond age 65 for at least a portion of the work force.

Following the 1978 ADEA amendments, the Department of Labor [DOL] published an interpretative bulletin on the amended act in May 1979. The DOL interpretation allowed employers to cease pension contributions and pension credits for active employees who work beyond the normal retirement age specified in their pension and retirement plans. Specifically, these rules interpret the ADEA to permit pension plans to: (1) Cease employer contributions at "normal retirement age" (65 years of age under most plans); (2) cease credit of years of service, salary increases, and benefit improvements which occur after an employee reaches the normal retirement age specified in the plan; and (3) not adjust actuarially the benefits accrued as of normal retirement age for an employee who continues to work beyond that age. (29 CFR 860.120.)

Shortly after the publication of these interpretations, the administrative and enforcement authority under the ADEA was transferred from DOL to the Equal Employment Opportunity Commission [EEOC]. The EEOC subsequently commenced a review of the factors relevant to the DOL interpretation by requesting public comments on the continuation of present practices. (48 FR 41436, Sept. 15, 1983.) Numerous groups and individuals responded to the request, providing the EEOC with hundreds of pages of information, most of which supported prohibiting employers from discontinuing pension benefit accruals at the normal retirement age. EEOC evaluated the public responses and, on June 26, 1984, voted to rescind the DOL opinion that accruals were not required and to replace it with a new proposal that will require continued contributions and crediting for workers past normal retirement age.

Despite the Commission's unanimous vote to move forward with the change, a number of procedural processes, such as obtaining comments from other concerned Government agencies and approval by the Office of Management and Budget were still pending at the agency at the end of 1986. The failure of EEOC to act on its policy change caused older worker groups to call for a legislative response to pension accruals.

Supporters of the current interpretations oppose any change in that status quo on the grounds that a change in the rules would cost employers an exorbitant amount of money. Employers argue that when the Employee Retirement Income Security Act, which regulates private pension plans, was enacted, Congress unequivocaly determined that retirement plans would not be required to recognize employment beyond normal retirement age either by accruing benefits or by actuarial adjustments to existing benefits. Further, they suggest that the legislative history of the 1978 amendments to the ADEA confirm congressional intent allowing reductions in employee benefits on the basis of age. If this viewpoint is correct, and the ADEA amendments were not intended to change the intent manifested by Congress at the time ERISA was passed, then legislation is necessary to require employers to continue benefit accruals.

Proponents of continued pension benefit accruals beyond normal retirement age have argued that the current DOL/EEOC interpretations, insofar as they permit pension to be frozen or suspended, are contrary to ADEA's policy promoting employment of older persons by prohibiting employer discrimination against older employees based on age alone. Reversing the 1979 interpretation would advance the individual civil rights of older employees by removing one more barrier to equal employment opportunity for older workers. They argue that the absence of pension accruals can be very costly to older employees. While relatively few older persons choose to work after age 65, halting accruals for those who do results in a substantial loss of retirement benefits. Indeed, an October 1984 study by the Employee Benefit Research Institute found that an employee delaying retirement can lose up to half the value of benefits accrued at age 65. This loss, in turn, acts as a disincentive to continued employment and may discourage employees from postponing their retirement. It is also argued that freezing pension benefits at normal retirement age confers an underserved windfall on employers. They suggest that the purpose of pension plans, which is to increase the retirement income of the elderly, could be furthered at little or marginal cost to the employer by extending the accrual of pension benefits beyond normal retirement age.

In the past there has been a dearth of empirical information to help discern the costs of requiring employers to continue pension contributions. To help rectify this situation, the American Association of Retired Persons commissioned William M. Mercer-Meidinger, Inc., to do a comprehensive study of the cost to employers and the benefits to employees if the practice of ceasing pension contributions was eliminated. The major findings of the October 1985 study, which was printed by the Special Committee on Aging, are:

1. The total annual value of pension benefits lost because employers do not grant full pension credit to those employees working beyond age 65 is approximately $450 million.

2. If there is no increase in the number of employees over age 65 and pension plans provide continued contributions and crediting, the increase in the employer cost in the first year

would amount to $51.5 million, less than one-tenth of 1 percent (0.08 percent) of total U.S. pension costs. Over 20 years, the annual employer cost increase would remain under 1 percent.

3. As the number of employees over age 65 increases, employer pension costs will decline since the costs of continued contributions and crediting is more than offset by gain that results from the shortened duration of pension payments.

4. If post-65 pension contributions and crediting encourage more employees to work beyond age 65, substantial Social Security benefits would not be paid. The study estimates that if age 65 through 69 employment increases by 10 percent, yearly Social Security benefits not paid would be $295 million.

Opponents of the exemption of pension accruals also note that half of all plan sponsors already permit continued accrual, apparently without putting an undue strain on their plan. This is largely due to the employers' ability to fund such continued accruals over the entire length of an employee's career, thereby spreading out the cost to make it more manageable. Finally, if discontinued accruals cause earlier retirement, pension plans will be required to pay out benefits earlier and for a longer period of time. This negates any savings that might have occurred because of discontinued accruals.

6. Apprenticeship Programs

Interpretations currently in effect at the Department of Labor, exempt apprenticeship programs from coverage of the ADEA. This, in effect, permits employers and labor unions to exclude men and women over age 40 from entering these programs solely on the basis of their age. The Department of Labor has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector since they are widely seen as a training program for youth in which the initial investment and training can be recouped over the apprentice's worklife. Elimination of the exemption is also opposed on the ground that it will cause an even higher rate of joblessness among the country's youth. The counter to this argument, however, is that the higher unemployment rate has continued despite the current regulations, which indicates that age limits in apprenticeship programs do not bear on youth unemployment levels.

A 1983 decision in *Quinn* v. *New York State Electric and Gas Corporation,* 569 F. Supp. 655 (1983), held that neither the language of the ADEA nor its legislative history support a conclusion that Congress intended to exempt apprenticeship programs from the ADEA. Following this decision, the EEOC decided to reconsider the exemption and, on June 13, 1984, voted a rescind the current exemption and issued proposed regulations which would prohibit arbitrary age discrimination in such programs. The regulations, however, have languished before the Office of Management and Budget, apparently because the Department of Labor has opposed the proposed change. In the meantime, the current age restrictions are having a serious adverse effect upon the employment opportunities and economic fortunes of older workers.

7. HEALTH COSTS

While we have witnessed a steady decline in labor force participation by older people over the past several decades, concerted efforts are now being directed toward reversing this trend. "Worklife extension" is the term used to describe the move to extend the worklife of older persons willing and able to work. An important theme in the discussion of worklife extension is the health of the older population. Employers and policymakers are concerned about the health implications of extended worklife, especially as they relate to issues of labor supply, productivity, employee health costs, and health maintenance.

A February 1985 information paper entitled "Health and Extended Worklife," prepared for use by the Special Committee on Aging, presents information about the health status of older persons as it may relate to extended work lives. The findings of the study indicate that the noninstitutionalized older population, and particularly the younger members of that population, are healthier than is widely believed. Health is one of several variables which affect the supply of workers, their level of productivity, and their utilization of health services and the new data presented in the paper will assist the Congress and employers in making informed decisions about employment and retirement issues.

Conventional wisdom suggests that older workers are paid more than younger workers for the same job and that, therefore, older workers are more expensive. This rationale has frequently been used to support early retirement programs on the assumption that younger workers can be hired at lower cost to replace older workers. There is, unfortunately, a dearth of empirical information to help discern whether it costs more to employ older workers than younger workers. In September 1984, the Senate Aging Committee released an information paper which examines factors related to patterns of labor costs by age, and discusses direct compensation, employee benefits, turnover, training, performance, and productivity.

The evidence indicates that there are some types of employment costs which vary by age, and that overall compensation costs increase by age, largely because of increasing employee benefit costs. There is, however, no statistical evidence that direct salary costs on an economywide basis increase by age. Employee benefit costs are not usually separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs, combined with an expanding set of laws and regulations, have served, however, to focus the spotlight on employee benefit costs for older workers, and it is possible that employers will give more consideration to this issue in the future.

The belief that older workers cost more seems generally related to feelings about performance and productivity. There is no statistical evidence to indicate generally poorer performance or productivity by age, and the limited data available refutes the basic notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work changes and the skills of the employee are not kept up to date, there will be an increasing mismatch of skills to the job, leading to deterioration of performance on that specific job. If older workers are to be cost-effective, their skills must be continuously updated through training and education to assure continued productivity. The two major conclusions of the information paper are as follows:

—It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills to compete on a fair basis for jobs within or outside of their companies. Up-to-date skills are more important than any age-related capabilities in human resource cost and older worker productivity.

—Legislative and regulatory requirements affecting employment costs for older workers should not place undue cost or administrative problems on employers. Such requirements can discourage the employment of older workers.

A 1986 report by the American Association of Retired Persons entitled, "Workers Over 50: Old Myths, New Realities," found that 62 percent of responding firms found that the extra cost of health insurance for employees age 50 and over to be insignificant compared with total company health care costs. Only 16 percent of the employers related a 55-year-old employee as being extremely costly to insure, as compared to 34 percent of firms which rated a 30-year-old with two dependents very expensive to insure.

Employer's concerns about the rising cost of providing health insurance for older workers, however, has been worsened by recent legislative action. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising costs of Medicare by shifting costs to private payors. The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], legislated changes in Medicare coverage for older workers. As of January 1983, employers could no longer advise workers that they were to be dropped from company group health insurance plans at age 65 because they were eligible for Medicare. TEFRA requires that company plans bear the primary insurance costs of illness, while Medicare becomes secondary. The TEFRA requirement raised employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any of its employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69—about 37 percent of all private sector workers in this age group—will be affected by these changes, at a total cost to employers of about $500 million. About 286,000, or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. In addition, about 148,000 workers who were previously excluded from coverage are likely to be covered by employer plans. The health plan costs of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concludes that these changes may initially reduce the demand for workers of this age by about 1 percent.

Two major provisions in the Deficit Reduction Act of 1984 [DEFRA] also have some effect on the costs of employing older workers and on the costs to older workers of remaining employed longer. The first is section 2301 of DEFRA, which modified the working aged provision—originally included in TEFRA—such that employers must offer group health coverage to an employee who has not reached age 65, if the employee has a spouse aged 65 through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer coverage that is the same as that offered to employees with spouses under age 65. In such cases, Medicare would be the secondary payer, while the employer sponsored plan would be primary. The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors they are significant. Now employers have yet another reason not to hire or retain older workers—those under age 65—because if they have an older spouse, the employer, rather than Medicare, is required to pay the health costs for the spouse. These added costs may encourage employers to steer clear of older workers.

The second provision, section 2338 of DEFRA, removed a disincentive to older workers of remaining on their employer's health plan. Under the TEFRA provision, those employees who elected, after age 65, to remain in the employer health plan would have been penalized for not enrolling in part B of Medicare upon their 65th birthday. This penalty amounted to a 10-percent increase on annual premiums for each 12 months that the employee does not enroll after his or her 65th birthday. Since the Medicare coverage was duplicative of the employer plan there was no need to enroll in part B until after retirement—except for the stiff penalty imposed. DEFRA waived the part B premium for workers and their spouses aged 65 through 69 who elect private coverage under the provisions of TEFRA. It also established special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

Finally, employers health care insurance obligations to older employees under the ADEA are expanded by the fiscal 1986 budget reconciliation bill (Public Law 99-272) signed by the President on April 7, 1986. The new law removed the upper age limit of 69 and employers will now be required to offer employees and their spouses aged 69 and over the same group health insurance coverage provided to younger workers.

Another issue is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. Indeed, in 1983 the Wall Street Journal reported that insurance companies know that groups with older people in them will run up bigger medical bills than those with younger participants. As a result, insurance premiums for the group have soared and some insurance companies have gotten out of the small-group business altogether as unprofitable. The employer, in turn, has been forced to shop for cheaper coverage, but even this is becoming more difficult as the companies that still cover small groups are being extra selective. Higher insurance premiums for veteran employers can mean another disincentive for those employers to hire and retain older workers.

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable example of this are the 1983 amendments to the Social Security Act. The compromises that resulted in the amendments (Public Law 98-21) reflect the belief in Congress that older people are healthier today and therefore, can continue to work longer. The desired effect of the amendment is that older workers will be discouraged from leaving the labor force by an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

8. Personnel Practices for an Aging Work Force

One of the most important issues before the Congress today is the need to expand employment opportunities for those older men and women who want to work full or part time. Substantial numbers of retired people would like to do productive work, rather than retire full time, but only if more appropriate and flexible employment opportunities are made available to them and existing financial disincentives are removed. The Bureau of National Affairs reported 1986 survey results which showed that only 6 percent of responding employers had a policy of encouraging older workers to stay on the job and just 2 percent of the firms provide retraining specifically for the older employee.

A major problem in the proliferation of innovation among business leaders with regard to older worker policies is the absence of information about models that have been tried in the private sector. Examples of new personnel policies and innovative work options to accommodate the unique needs of older workers are given in a February 1985 information paper, "Personnel Practices for an Aging Work Force: Private Sector Examples", prepared for use by the Special Committee on Aging. The information paper fills an important information gap by providing employers, policymakers, and the general public with descriptions of successful employment practices designed to capitalize on the contributions of older workers.

A relatively recent development has been the use of early retirement options, with enhanced benefits for senior employees. Many employers, faced with having to tighten their belts and reduce the size of their workforce, have begun offering their older employees (with high salaries), financial incentives to leave the workplace. In 1986, for example, three major companies (duPont, IBM, and Xerox) announced early retirement incentives to trim their workforces.

As the use of exist incentives have rise, so have questions about their discriminatory effect. The ADEA states that certain exit incentive programs can include provisions which would otherwise be considered discriminatory, but only if they are not used as a subterfuge to evade the purposes of the ADEA. This has been interpreted to permit differential benefits, but only where justified by the increased cost of providing benefits to older workers. At this time, there are divergent circuit court rulings on the cases testing the legality of existing incentives. While it is too soon to understand all of the implications of this new trend, economists have expressed concern at the loss of so many productive workers. The use of early retirement incentives is of growing interest to older workers advocates, as well as to employers, and the issue is sure to be closely monitored by watchdog interest groups.

C. RESPONSES

1. LEGISLATION

After years of research, hearings and public awareness campaigns by the House and Senate Aging Committees, legislation was finally enacted in the waning days of the 99th Congress to abolish mandatory retirement at any age for most occupations. The pressure for this legislation came not only from the aging organizations, which have long supported the elimination of age-based retirement, but also from State and local jurisdictions, the Fraternal Order of Police, the International Firefighters Union and other groups who sought an exemption from the ADEA for public safety officers.

The debate centered around three major issues: (1) The elimination of mandatory retirement and whether the enforcement procedures specified in the original ADEA should be modified; (2) whether a tenured faculty exemption should be allowed and, if so, for how long; and (3) whether an exemption allowing early forced retirement should be added for State and local law enforcement and firefighting personnel. Each of these concerns is discussed below.

(A) MANDATORY RETIREMENT PROVISIONS

On May 2, 1985, Senator Heinz introduced S. 1054, the Age Discrimination in Employment Amendments of 1985, to remove the maximum age limitation (age 70) for employees covered by the ADEA. In the House of Representatives, similar legislation (H.R. 4154) was introduced by Congressman Claude Pepper on February 6, 1986. The effect of removing the upper age limit would be to protect workers age 40 and above against discrimination in all types of employment actions, including mandatory retirement, hiring, promotions, and terms and conditions of employment. Thus, S. 1054 drew no distinction between the people already employed and the people seeking employment or promotion. Further, no exemptions from the act for any class or category of workers were contained in the bill as introduced.

The House of Representatives passed H.R. 4154 on September 23, 1986. When the House bill came over to the Senate, many aging organizations and the bill's Senate sponsor opposed a permanent exemption that had been added to allow forced retirement for public safety officers. Other groups and Members were equally concerned that the bill, as passed by the House, did not concern even a temporary exemption for tenured faculty. In the closing days of the

99th Congress, compromises were made and agreements were reached that finally permitted Senate passage, on October 23, 1987, and by unanimous consent, of a modified version of H.R. 4154.

The legislation was signed by the President on October 31, 1986 (Public Law 99-592). The law removes the age 70 limit in the ADEA so that the act's provisions will apply to covered employees 40 years of older as of January 1, 1987. Other anti-discrimination protections in the act, such as protections in the areas of hiring and promotion, are still applicable. The law provides for two temporary exemptions, which are described below.

(B) TENURED FACULTY EXEMPTION

During consideration of S. 1054 and H.R. 4154, several legislative proposals were made to allow tenured faculty to be mandatorily retired. A compromise was finally worked out allowing a temporary exemption.

The exemption allows institutions of higher education to set a mandatory retirement age of 70 years for persons who are serving under tenure. This provision is in effect for 7 years, until December 31, 1993. The law also requires the EEOC to enter into an agreement with the National Academy of Sciences to conduct a study to analyze the potential consequences of the elimination of mandatory retirement for institutions of higher education. The study findings are to be submitted to the President and to Congress within 5 years of enactment. The law sets forth the composition of the study panel, including administrators, and teachers or retired teachers, at institutions of higher education.

(C) STATE AND LOCAL PUBLIC SAFETY OFFICER PROVISIONS

The amendment offered by Representative Murphy, added to H.R. 4154 in the House by a vote of 291 to 163, provided that public safety employees would be subject to the jurisdiction of States and local governments to determine whether or not they should be hired and whether or not they should be allowed to continue to work at any age. This amendment amounted, in effect, to a permanent exemption to the hiring and firing protections of the ADEA for police and firefighters. No other exemptions were contained in the House passed bill.

The Senate compromise allowed a temporary exemption for State and local public safety officers. This temporary exemption was approved by both the House and Senate and signed into law.

The exemption allows State and local governments to refuse to hire or to discharge law enforcement officers and firefighters based on their age if such persons had attained the age of hiring or retirement under a State or local law which was in effect on March 3, 1983 (following the Supreme Court's decision in *EEOC* v. *Wyoming*), pursuant to a bona fide hiring or retirement plan. This provision is in effect for 7 years, until December 31, 1993. The legislation also requires the Secretary of Labor and the EEOC to conduct a study and to report to Congress on whether physical and mental fitness tests can be used as a valid measure to determine the competency of police officers and firefighters and to develop recommendations on standards that such tests should satisfy. The study is to be submitted to Congress within 4 years of enactment of the law. The law also requires that within 5 years of enactment, the EEOC propose guidelines for the administration and use of physical and mental fitness tests to measure the ability and competency of police and firefighters to perform their jobs.

(D) PENSION ACCRUAL PROVISIONS

On September 19, 1986, the Senate passed its version of the budget reconciliation legislation, and included an amendment offered on behalf of Senator Grassley which required continued pension benefit accruals for employees who continue to work beyond normal retirement age. House and Senate conferees worked out a compromise on the provision which was approved by Congress on October 17, 1986, and subsequently signed by the President (Public Law 99-509).

The provision prohibits any employee benefit plan from ceasing accruals or suspending plan contributions for an employee because of age. Employers will be allowed to discontinue accruals if the employee has reached a maximum benefit, a maximum number of years of service or maximum years of participation in the plan if these limits are "without regard to age." Employers are also allowed to offset actuarial increases against the accrual provision and employers would be able to establish a "floating" normal retirement age that could not be later than the fifth anniversary of the employee's participation in the plan. The effective date of this new provision is January 1, 1988.

The legislation corrects an anomaly in the law and is a significant victory for the 150,000 to 200,000 employees 65 through 69 years of age whose benefit accruals were frozen at age 65. Passage of the pension accrual provisions provides older workers fair pension treatment and eliminates one more obstacle to the employment of older persons.

2. EXECUTIVE AND REGULATORY ACTIVITIES

(A) WAIVER OF RIGHTS

In the past, the EEOC recognized that application of the FLSA enforcement provisions to the ADEA may be interpreted to mean that individuals may not waive their rights or release potential liability even if the action is voluntary and knowing, except under EEOC supervision. On October 7, 1985, however, the EEOC published a proposed administrative exemption and legislative regulation under the ADEA allowing for non-EEOC supervised waivers and releases of private rights as an exemption to the ADEA for "any waiver of rights or release from liability by an employee or job applicant under the act that is voluntary and knowing." (50 FR 40870, Oct. 7, 1985.) The exemption would allow employers and employees or job applicants to issue private agreements which contain waivers and/or releases of private rights under the ADEA without the supervision or approval of the EEOC. The Commission believes that the remedial purposes of the act will be better served by allowing agreements to resolve claims whenever employees and employers preceive them to serve their mutual interests, provided such waivers of rights are knowing and voluntary. To this view the Commission cites the similarities between the ADEA and title VII of the Civil Rights Act of 1984 and notes that under title VII, such unsupervised waivers of private rights are permissible.

Because the proposal to grant blanket waivers of individuals' ADEA rights without Government supervision represents a significant change in current law and practice, and could threaten older workers' basic rights and protections, their rescission was urged by Senator Heinz, Chairman of the Senate Special Committee on Aging and Representative Roybal, Chairman of the House Select Committee on Aging. The Commission is reviewing Comments from interested persons and has not yet reached a final decision on the proposed rule, but it is expected that the EEOC will proceed to issue final regulations allowing waivers.

Opponents of the proposed exemption say that it is overly broad in that it applies not just to certain employers or employees in certain exceptional circumstances, but rather to any and all employers or even job applicants under every conceivable circumstance. The public interest served by the proposed regulation would have to be considerable in order to justify the breadth of this proposed exemption. Opponents argue, however, that the only public interest rationale offered in the EEOC notice of proposed rulemaking is that the exemption would promote the expeditious resolution of disputes. It is not clear how the broad exemption would provide for more expeditious resolution of disputes, and if it does promote that goal, whether that interest would outweight possible abuses of the exemption. They note that the EEOC discussion does not set forth any factual information as to the number of supervised waivers each year under the present law and the amount of time it takes for EEOC approval to be obtained for such requested waivers.

Opponents further argue that the proposed regulation does not state whether it covers the waiver of prospective rights. Additionally, the language of the proposed regulation does not limit itself to waivers or releases stemming from employment disputes between employer and employee or job applicant. Conceivably, an employer could ask a job applicant to agree that if the applicant were hired, that he or she would retire at a given age. Finally, opponents say that simple reliance upon analogous case law under title VII may only serve to complicate and prolong litigation under this section since the context of ADEA waivers is not exactly the same as for cases under title VII. They contend that in many situations, it may be difficult to ascertain the state of mind of the employees as he or she agrees to waive statutory rights under the ADEA. The issue of knowing and voluntary waiver, particularly where unsupervised by an objective entity, such as the EEOC or a court, is one which, at the very least, should be accompanied by intrepretative standards or guidelines.

(B) NOMINATIONS TO KEY EEOC POSITIONS

In the fall of 1985, the administration nominated Jeffrey I. Zuckerman, a chief assistant to EEOC Chairman Thomas, to the position of EEOC General Counsel. The position is considered important because the chief counsel's job is to decide which case to prosecute under the equal employment laws and policies.

Many civil rights and aging organizations expressed serious reservations about Mr. Zuckerman's commitment to strong enforcement policies for discrimination in employment cases. They feared that his views would weaken the EEOC's effectiveness in litigating against workplace discrimination. Mr. Zuckerman also came under intense criticism from most Democratic and some Republican members of the Labor and Human Resources Committee for his opposition to traditional civil rights remedies and for having challenged a series of court rulings.

Statements made by Mr. Zuckerman, in an unprecedented 3 days of confirmation hearings, indicated that he disagreed with accepted policies and legal precedents in the areas of pension eligibility as a basis for termination or layoff, the use of "disparate impact" to prove age discrimination, post-65 pension benefit accrual, and apprenticeship programs.

On May 20, 1986, Mr. Zuckerman was rejected for General Counsel after three Republicans joined seven Democrats in opposing him. Because civil rights activists and senior citizens groups viewed the nomination as a barometer of changing EEOC policies, his defeat was seen as particularly significant and as a victory for strong equal employment enforcement.

In another action, the Senate confirmed Clarence Thomas, nominated by President Reagan for a second term as Chairman of the EEOC, without objection on August 12, 1986. The vote followed a 14 to 2 recommendation by the Labor and Human Resources Committee for his confirmation to the post, which he has held since February 1982.

D. PROGNOSIS

Despite a broad consensus that individuals should not be discriminated against based on their age, discrimination is still widely practiced and stereotypes of useless, burned-out older workers persist. Protections do exist for older workers to prevent and punish age discrimination—and these are important to the few who take advantage of them—but they are often incomplete and ineffectual. Demographic and legislative trends dictate that age discrimination issues will become more active both legally and politically—and will result in increased demand for clearer positions on the language found in the ADEA. While there is no good system for correlating age and the attributes required by certain jobs, the decade of the 1980's can be expected to bring increasingly accurate measurements of individual functional ability.

Passage of legislation abolishing mandatory retirement and of legislation requiring pension accruals was a victory for older workers and represented significant steps toward granting equal rights to all working Americans. They are not, however, expected to significantly change work and retirement behavior. Indeed, the clear trend is to leave the labor force at increasingly early ages in response to the increased availability of retirement income. The bills do indicate, however, Congress' continued interest in improving employment opportunities for older workers and expanding the work lives of older employees.

Chapter 5

SUPPLEMENTAL SECURITY INCOME [SSI]

OVERVIEW

The SSI Program was subject to only minor legislative changes in 1986. This was primarily because Congress confronted many major issues during 1984, the 10th anniversary of the program. In 1984 Congress enacted a number of program improvements as part of the Deficit Reduction Act of 1984 [DEFRA]. Most notably, Congress increased the resources test for individuals from $1,500 to $2,000 and for couples from $2,250 to $3,000. These increases were scheduled to be phased in over a 5-year period. Congress also limited to 10 percent the amount that SSA could withhold from recipients' benefit checks as a means of recovering overpayments. The passage of the Social Security Disability Benefits Reform Act in 1984 also produced a major impact on SSI because the standards for determination of disability are the same under SSI and Social Security disability insurance.

In recent years SSI has escaped the budget cutting efforts directed at other means-tested programs. It remains problematic however, as to whether or not SSI protected status will continue in the face of the enormous budgetary pressures that Gramm-Rudman-Hollings is expected to generate in future years.

A. BACKGROUND

The Supplemental Security Income [SSI] Program provides a guaranteed minimum income to the Nation's aged, blind, and disabled. Enacted in 1972 as title XVI of the Social Security Act, SSI was designed to establish a uniform, national income floor to ensure the economic security of America's most needy and vulnerable groups. Just under 3.9 million people receive benefits from SSI, with maximum Federal monthly benefits in 1986 amounting to $336 for individuals and $504 for couples. SSI is financed through general revenues, and is administered by the Social Security Administration [SSA].

SSI was created to consolidate at the Federal level three State administered public assistance programs—old-age assistance [OAA], aid to the blind [AB], and aid to the permanently and totally disabled [APTD]. Congress intended that Federal financing and administration would:

(1) Simplify administration of welfare and provide fiscal relief to the States;

(2) Provide more adequate, more uniform, and more equitable benefits;

(3) Reduce the stigma of welfare by making payments through SSA and thereby associating SSI with social insurance;

(4) Improve incentives for the poor to seek employment; and,

(5) Decrease harassment of recipients by eliminating obstructive eligibility investigations to determine need, and doing away with lien and relative responsibility laws.

After a decade of program operation, the basic structure and purpose of SSI has not changed in any substantial way. Legislation addressing SSI has primarily focused on improving administrative efficiency, increasing intraprogram equity, and protecting former recipients of the State programs from losing benefits due to federalization.

To qualify for SSI, an individual must be 65 or over, blind, or disabled, and demonstrate need for income supplementation. Need is determined through a means test which is an evaluation of income and assets in relation to established maximum standards. In 1986, recipients' unearned income (Social Security and other benefits) cannot exceed by more than $20 the maximum Federal SSI benefit ($336 for individuals, $502 for couples). In addition to meeting the income test, assets may not exceed $1,700 for an individual or $2,550 for couples. However, in calculating assets, the value of a person's home is not counted, nor are the first $4,500 in fair market value for an automobile and the first $2,000 in equity value for household goods and personal effects. Regulations also provide guidelines for determining the countable value of certain other assets, such as burial plots and life insurance policies. Eligibility criteria for SSI are summarized below:

Basic SSI eligibility conditions

Aged	65 or older.
Blind	Vision no better than 20/200 or limited visual field of 20 degrees or less with the best corrective glasses.
Disabled	A physical or mental impairment which prevents a person from doing any substantial work and is expected to last at least 12 months or result in death.
Resource limits [1]	$1,700 for individuals and $2,550 for couples.
Income limits [2]	$340 per month for individuals, and $510 per month for couples.
Citizenship	U.S. citizen, immigrant lawfully admitted for permanent residence, or other persons residing in the United States under color of law.
Residency	Resident of the United States or the Northern Mariana Islands.

[1] Limits as of January 1, 1986. Not all resources are counted in determining eligibility.

[2] Limits as of January 1, 1986. Reduced benefits may be available for persons earning up to $757 per month. Not all income is counted in determining eligibility. Also, a person may have income above the limit and possibly be eligible for State supplement only, but the income levels vary among States.

NOTE.—Disabled must accept vocational rehabilitation if available. Drug addicts and alcoholics must accept appropriate treatment if available.

B. ISSUES

1. INCOME LIMITS

From a policy perspective, many have criticized the income limits as being too restrictive. The income limits for SSI recipients leave a large number of people who fall below the poverty line ineligible for SSI. (The limit for individuals is $340 per month, or $4,080 per year; for couples it is $510 per month, or $6,120 per year.) Second, the law requires that gifts or inheritances, which may not be readily converted into cash, be treated as income in the month they are received. For instance, if an elderly SSI recipient is given a portable radio by her granddaughter, or inherits a kitchen table from a brother who died, she must report receipt of these gifts to SSA, and their value will be subtracted from her SSI check. Many have criticized this treatment of gifts as income as a disincentive to family and community involvement in meeting the needs of SSI recipients.

2. ASSETS LIMITS

Assets limits have increased only slightly since 1974, despite a 120-percent increase in the Consumer Price Index [CPI] over the same period. Today, it would take almost $3,000 and $5,000, respectively, to purchase what $1,500 and $2,250 could purchase in January 1974, yet these limits have only been raised to $1,700 and $2,550, respectively. The 1984 changes which will gradually raise asset limits to $2,000 for individuals and $3,000 for couples by 1989. The delay for a decade in raising the limits and the relatively small increase in the asset limits have added to a serious deterioration of the availability of SSI over time.

The cutoff in the SSI assets test also contributes to the problem of overpayment and overpayment recovery in SSI. Currently, if a recipient goes over the limit even a small amount, perhaps from interest in a bank account, that person is deemed ineligible for SSI in the month or months in which there is an excess. This ineligibility usually leads to substantial overpayments, due to the fact that the errors usually are detected only after the full benefits have been paid to the recipient. Approximately 20 percent of all overpayment errors in SSI result from problems associated with bank accounts. Significantly, these errors account for about 50 percent of the dollar amount to be collected as overpayments. This problem was exacerbated by SSA's recent policy of aggressively recovering overpayments, and rarely waiving the obligation to pay back to SSA the funds overpayed.

Though there are significant problems with the assets test, many argue that it serves a critical purpose in ensuring that only people with few or no resources receive benefits, and that eliminating the tests would create more problems than it would resolve. For instance, outright elimination of the assets test might open the program to those with limited income, but would also discourage the conversion to cash of significant resources that might otherwise be used for self-support. Other than eliminating it altogether, there are a number of methods of revising the assets test. Congress could, for instance, limit the amount of overpayment incurred by exceeding the assets limits to the dollar amount in excess, or Congress could exclude certain assets, such as insurance policies, from the calculation.

Alternatively, Congress could fold the evaluation of assets into an expanded income test, where assets are translated into an "income stream" over time. Assets would be totaled, and then converted into a stream of cash income, using a set of specific actuarial assumptions (such as live expectancy tables, projected interest rates) to make the calculation. Under the current structure, it is assumed an individual will consume available assets until they drop below the SSI threshold; at that point, income supplementation will begin. Under a plan to annuitize the value of assets, an individual would receive SSI income supplementation while spending down his or her recources over time. This would eliminate the problem of an arbitrary cutoff point for people who are cash poor, but happen to have some available resources. A major problem with this approach is the difficulty of designing the basic assumptions that would guide the valuation of assets over time. Further, such a change could be costly by allowing a large number of presently ineligible individuals to qualify for benefits.

3. BENEFITS

Criticism of the benefit structure in SSI has focused recently on the one-third reduction rule for recipients living in the home of another, and the personal needs allowance for institutionalized recipients. In January 1987, the maximum Federal monthly payment is $340 for an eligible individual and $510 for an eligible couple. The law requires a benefit reduction of one-third for those who live in another person's household and who receive support and maintenance from that person or persons. Many groups, including the 1981 National Commission on Social Security, have recommended that the one-third reduction be eliminated. It is a very complex provision to administer, and it serves as a disincentive to SSI beneficiaries to live with others. It may be counterproductive to discourage SSI recipients with mental and physical disadvantages from living with others who may be able to provide support.

Persons who reside in public institutions are usually ineligible for SSI benefits. However, if a person lives in a community care facility serving no more than 16 people, that individual can often receive SSI benefits. Residents of larger health care institutions in which Medicaid is paying for more than half of that individual's care are eligible for a maximum $25 monthly SSI benefit, the Personal Needs Allowance [PNA], which is intended to cover personal comfort items.

Two problems emerge in the area of SSI benefits for those living in institutions. First, the 16-person limit for community care excludes residents of shelters for the homeless, and larger, shared housing arrangements for mentally impaired individuals who need assistance in daily living. Second, the $25 PNA for residents of nursing homes has not been changed since 1974. With the inflation that has occurred in the past decade, the value of this monthly allowance has substantially eroded. Many advocates have begun calling for an increase in the PNA, claiming that this group deserves inflation-protected benefits. Others argue that an increase in the allowance would only lead to increased charges by nursing home operators for those things often purchased with PNA funds such as laundry services.

4. PARTICIPATION

Despite initial projections that over 7 million Americans would participate in SSI, the total SSI caseload has never exceeded 4.5 million. Early assumptions that over 90 percent of the eligible population would benefit from SSI were proven too optimistic; in reality, a conservative estimate of the participation rate is closer to 60 percent.

These low levels of participation are difficult to explain. Few surveys of the attitudes and opinions of the SSI population have been undertaken, and alternative interpretations of the problem have often been based upon anecdotal information.

Typical explanations of low participation rates in SSI among the elderly include: (a) The stigma associated with welfare; (b) very small benefit amounts for many who near the maximum income and resource limits; (c) barriers of literacy, mental and physical handicap, and access to transportation; and (d) SSI's administrative complexity, which requires a great deal of effort on the part of participants.

5. ELIGIBILITY OF SSI RECIPIENTS FOR OTHER PUBLIC ASSISTANCE PROGRAMS

SSI recipients often qualify for additional Federal public assistance from a variety of programs, most notably Medicaid and Food Stamps. The relationship between SSI and Food Stamps has changed over the last decade. Originally, SSI beneficiaries were prevented by the statute from receiving food stamps. This exclusion was eliminated in 1977 by Congress, by virtue of the fact that it seemed inequitable that AFDC recipients, as well as people whose income or assets exceeded SSI limits, could qualify for food stamps while SSI beneficiaries could not. Currently, SSI recipients can apply for food stamps in SSA district offices, where eligibility determinations are made in accordance with conventional food stamp guidelines. In California and Wisconsin, food stamps are "cashed out," or converted into cash as part of monthly SSI payments.

States are required to offer Medicaid to SSI recipients if the recipients are eligible under the State's 1972 eligibility criteria. The 1972 legislation creating SSI gave States the option of allowing SSA to determine Medicaid eligibility, if the States were willing to accept SSI eligibility as a condition for Medicaid coverage. Currently, more than half the States allow SSA to execute Medicaid determinations for SSI recipients. Medicaid is perhaps the most valuable ancillary Federal program for SSI beneficiaries, and adds significantly to the adequacy of SSI coverage.

Medicaid is often more important to many SSI recipients than cash benefits, and there are a number of instances in which small increases in outside income, and corresponding ineligibility for SSI, will cause the loss of Medicaid benefits. For instance, a 60-year-old woman may become eligible for Social Security widow's benefits and concurrently lose eligibility for SSI and Medicaid, while not becoming eligible for Medicare. The loss of Medicaid often far outweighs the value of the increase in cash benefits to these individuals.

Another area of concern is the effect of assistance provided by private nonprofit organizations to SSI recipients (e.g., free food from soup kitchens or help with utility bills) on their eligibility. Those who advocate including this type of aid in countable income point out that SSI is a strict, means-tested program, and to the extent that applicants or recipients have available means, whether earned or provided for free, they should be evaluated against the objective standards that limit eligibility for benefits. Opponents of this policy argue that such assistance should be excluded from countable income, particularly because it serves the emergency needs of many very low-income recipients, placing the poor in the catch-22 of qualifying for aid and then losing it because of other assistance. Also, counting this aid as income discourages charitable involvement in providing for the poor.

6. Employment and Rehabilitation for SSI Recipients

One of the foundational objectives of SSI was to create a welfare program that had the least possible disincentives to employment. At no time, however, has more than a tiny fraction of the SSI caseload received income from earnings (in December 1983, for instance, only 3.3 percent of all recipients reported earnings).

The low rate of employment of SSI recipients is a product of a number of factors. First, SSI recipients under age 65 are by definition severely disabled. Even those who might have some limited capacity to work have difficulty finding suitable employment. Second, there are major work disincentives built into the structure of SSI. For instance, an individual may be able to secure earnings that are more advantageous than the SSI benefit, but the loss of Medicaid coverage, given the difficulty of obtaining substitute health insurance with a pre-existing condition, more than offsets the increased income.

The Social Security Disability Amendments of 1980 (Public Law 96-265) included changes that were meant to encourage SSI recipients to seek and engage in employment. The relevant provisions, which became section 1619 of the Social Security Act, were designed to lessen the substantial disincentives to work in SSI. The 1980 amendments: (a) continued special monthly benefits, as well as Medicaid eligibility, for disabled recipients who have completed the 9-month trial work period and continue to receive earnings in excess of SSI income limits; (b) provide that impairment-related work expenses (including medication, attendant care, special equipment) could be deducted from countable income; and (c) treated money earned in sheltered workshops as earned, rather than unearned income for the purpose of calculating benefits.

The law limited these provisions to a temporary, 3-year trial period that expired on December 31, 1983. They were extended another 3 years in 1984, with the passage of the Social Security Disability Benefits Reform Act. Though definitive statistics are unavailable, it is estimated that between 400 and 500 people receive special SSI benefits and 5,000 to 6,000 recipients take advantage of the extended Medicaid benefits.

The relatively low level of utilization of these special benefits offered by the 1980 amendments appears to be a product of widespread unawareness of the existence of the provisions and of the fact that employment will not automatically terminate eligibility for SSI and Medicaid.

7. ADMINISTRATIVE ISSUES

One of the original assumptions justifying the creation of SSI was the notion that administration by SSA would eliminate the harassment and stigma associated with traditional, locally run welfare programs. Though SSA has eliminated some of the most embarassing aspects of receiving welfare—such as lien and relative responsibility requirements—critics have charged that some administrative policies have created problems for recipients in the past few years.

SSA's recent policy of collecting overpayments is perhaps the most extreme example of an insensitive approach to beneficiaries. Beginning in 1981, SSA launched a set of initiatives to increase their collection of SSI overpayments as part of a major governmentwide effort to improve Federal debt management. As part of this effort, administrative instructions were revised to replace the previous policy of withholding no more than 25 percent of a monthly check with a policy of withholding 100 percent of subsequent checks until the overpayment was recouped.

1984 legislation limited recovery of overpayments to no more than 100 percent of a beneficiary's check, but the negative impression of Government harassment of recipients will likely linger for some time.

In addition to the policy of withholding 100 percent of monthly checks to recover overpayments, SSA also instituted a policy of limiting waivers of overpayments. SSA also proposed new rules in February 1983 to limit the rights of recipients to request a waiver of an overpayment to within 60 days of the notification of the overpayments. These proposed rules never became final regulations, due to public opposition. Nonetheless, the proposed regulations, like the policy of 100-percent withholding, represent a change in attitude about the needs of the SSI population, and the basic mission of the agency.

C. SSI LEGISLATION

Although no major legislative changes in the SSI program were enacted in the 99th Congress, the Employment Opportunities for Disabled Americans Act (Public Law 99-643) made significant improvements in "section 1619 benefits." Section 1619, which allows severely impaired individuals to receive SSI and Medicaid benefits although their earned income exceeds program income limits, was made permanent when the act was signed into law on November 10, 1986. This enables disabled SSI recipients to earn as much as $757 per month before benefits are completely phased out, in contrast to the former $300 limit. It also allows the working disabled to maintain eligibility for Medicaid until their earning exceed $757 per month plus the value of State supplements and Medicaid benefits otherwise available.

D. PROGNOSIS

Throughout its 12-year history, SSI has been considered an essential element of the safety net of programs which protect the Nation's least-advantaged citizens. This role has protected the program from major cuts in recent years, but pressure on the budget has nonetheless prevented the program from expanding and from keeping pace with inflation. Given the decision to exclude SSI from the automatic budget cuts of Gramm-Rudman-Hollings, it is likely that Congress will continue to insulate the program from cuts. However, increasing pressure to reduce Federal budget deficits will most likely prevent growth of the program in the near future, and could even produce delays or cancellations of scheduled COLA's. Nonetheless, advocates of the program can be expected to continue attempts in 1987 to raise benefits to the poverty level, increase the personal needs allowance, improve access to the program, and eliminate perceived harsh aspects of program administration.

Chapter 6

FOOD STAMPS

OVERVIEW

At the end of 1985, Congress and the President approved a new "farm bill," the Food Security Act of 1985 (Public Law 99-198), which extended the authorization for food stamp appropriations for 5 years with appropriations that rise from $13 billion in 1986 to $16 billion in 1990. The food stamp provisions of the Food Security Act also made a number of significant changes in the program that, over a 5-year period, are expected to add about $800 million in new food stamp spending and increase funding for Puerto Rico's special nutrition assistance block grant (operated in place of food stamps) by nearly $300 million.

In 1986, the debate in Congress centered on two differing sets of proposals. Seeking Federal budget control, Senator Helms asked repeal of the liberalizations enacted in 1985 and the administration proposed additional spending cuts, national minimum standards for participation in work and training programs, and State option block grants instead of food stamps. In contrast, Congressman Panetta and Senator Kennedy recommended benefit increases to deal with a perceived need for greater food assistance efforts. Congress, however, chose not to take action on major food stamp proposals in 1986. Issues which did receive attention in 1986 included increased program access for the homeless, low income home energy assistance benefits and food stamps, treatment of student expenses, a ban against sales tax on food stamp purchases, and fiscal sanctions on States for erroneous issuance of benefits.

Congress chose to exempt the Food Stamp Program from any automatic spending reductions required under the Balanced Budget and Emergency Deficit Reduction Act of 1985 and fiscal year 1986 funding available for food stamps, including $820 million for Puerto Rico, was close to $12.6 billion. Even so, in 1986, the Food Stamp Program provided benefits to a somewhat smaller number of persons than in fiscal year 1985.

A. BACKGROUND

The Food Stamp Program provides a uniform national benefit floor in the form of enough food stamps for a nutritionally adequate diet, in combination with income available to the recipient household. The program is available everywhere and to everyone in equal need and is responsive to shifts in unemployment and to personal economic tragedy. The purpose of the program is to provide a means of obtaining a more nutritious diet when available income makes that impossible—and there is ample evidence that it has been successful.

The tremendous importance of the Food Stamp Program, especially to the elderly and to children, has recently been underscored by new studies that confirm that there is a direct connection between nutritional status and health. The Food Stamp Program has some special rules for the elderly—including more liberal treatment of shelter expenses, medical expenses, and assets. The program, for example, recognizes that elderly people with high medical bills may have total incomes higher than the poverty line, but no more money actually available for food than those with lower incomes and no medical bills. Although 18 percent of food stamp households had at least one elderly member (age 60 or over), they made up only 7 percent of all food stamp recipients and received 8 percent of food stamp benefits, because of the typically small size of elderly households. Elderly households are overwhelmingly (80 percent) made up of one or two persons. Over 14 percent of elderly households also included children.

The Food Stamp Program began as a group of pilot projects set up by Executive order in 1961 when the Federal Government began a small, experimental antihunger program in eight U.S. counties. As a result of the pilot projects, today's Food Stamp Program was authorized by the Food Stamp Act of 1964, which offered States the option of operating a Food Stamp Program in lieu of existing commodity donation programs. In 1977, the Congress enacted the Food Stamp Act of 1977, which completely revamped the Food Stamp Program's operation. Since then, various amendments have been enacted to improve the program and strengthen its integrity.

The Food Stamp Program is designed to help low-income households obtain more nutritious diets. Eligible applicants receive food coupons to buy food through normal market channels, primarily grocery stores. In addition to making food assistance available to eligible groups of people who, for one reason or another have difficulty meeting their nutritional needs themselves, the Food Stamp Program also serves as an income security program by supplementing available family income, contributes to farm and retail food sales, and reduces surplus stocks.

The Federal Government bears the cost of all food stamp benefits and shares, with the States and localities, 50 percent of most administrative costs. State and local costs associated with computerization and fraud control activities are eligible for 75 percent Federal funding. The Food and Nutritional Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At the State and local levels, the Food Stamp Program is administered by State welfare departments.

The Secretary of Agriculture has established uniform national standards of eligibility for a household's participation in the program. Basically, all households must meet a liquid assets test and, except for those with an elderly or disabled member, must meet a two-tiered income test to be eligible for benefits. Recipients in two primary Federal-State categorical cash welfare programs—Aid to Families with Dependent Children and Supplemental Security Income [SSI]—are automatically eligible for food stamps. The household's monthly gross income must not exceed 130 percent of the income poverty levels set by the Office of Management and Budget, and its monthly income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty levels.

Certain able-bodied adult household members must register for employment and accept a suitable job if offered in order to maintain eligibility. States are required to operate work and training programs under which those work registrants not exempted by the State must fulfill employment requirements established by each State. These requirements may include workfare obligations, supervised job search requirements, participation in a training program, or other employment or training activities designed by the State.

Applicant households that are certified as eligible are entitled to a specific level of benefits—generally in the form of food coupons, which are accepted by authorized food stores in exchange for food. The level of benefits is based on USDA's thrifty food plan, which estimates how much it would cost a household that shops economically to meet its nutritional needs. Because a food stamp household is expected to spend 30 percent of its disposable income for food, the food stamp benefit equals the amount by which the thrifty food plan exceeds 30 percent of the household's net income. Under the food stamp eligibility rules, as many as 30 to 35 million persons may be eligible for food stamps nationwide. although only about 20 million persons actually participate in an average month. In fiscal year 1986, the maximum food stamp benefit to a one-person household is $81 and for a two-person household the maximum is $149 a month. Actual benefits in 1985 averaged $45 per person per month.

B. ISSUES

Throughout the 99th Congress, debate focused on whether the Food Stamp Program has been too liberalized, justifying further savings, or whether the program needs to be expanded. Framing this debate are alternative assumptions about the extent of hunger in the United States, and the role and adequacy of food stamps in combating it.

1. The Hunger Debate

The first major publicity about hunger in America came after a visit to the rural South in April 1967 by members of the Senate Subcommittee on Employment, Manpower and Poverty to hold hearings on the effectiveness of the war on poverty. Members of the subcommittee were told of hunger and poverty. Later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. When the physicians returned in 1977 to evaluate progress made in combating hunger, they found dramatic improvements in the nutritional status in those same areas. The improvement was attributed to the expansion of Federal food programs in the 1970's. Many believe that the Food Stamps Program ranks as one of the most effective efforts to combat hunger and poverty in recent years.

Over the last few years, considerable media attention has been focused on the re-emergence of hunger in the United States. In 1981, news accounts of bread lines and crowded soup kitchens began to appear in papers in various cities around the country. In October 1982, the U.S. Conference of Mayors reported that in most of their cities surveyed, the need for food represented a most serious emergency. In June 1983, the conference issued a report entitled "Hunger in American Cities" in which they reported a dramatic increase in hunger in the cities of the Nation. Closely following that report, the General Accounting Office reported widespread and growing hunger in America and found that persons in need of food include both those left out of Government nutrition programs as well as those for whom assistance is simply not enough on which to live. In December 1983, Senator Edward Kennedy issued to the Senate Committee on Labor and Human Resources, a report entitled "Going Hungry in America." Based on a field investigation undertaken the week before Thanksgiving 1983, Senator Kennedy's report found that hunger was on the rise in America, and that Congress must act to improve assistance to the hungry.

In August 1983, to investigate the allegations of rampant hunger in the United States, President Reagan appointed a commission to study the problem. At the end of 1984, the President's Task Force on Food Assistance released its report to Congress and to the public. Although the report acknowledged pockets of hunger, it asserted that there was little evidence of widespread hunger in the United States and that reductions in Federal spending for food assistance had not injured the poor. Several modest recommendations to make the Food Stamp Program more accessible to the hungry were included in the report. These included: Liberalized rules governing liquid assets and car ownership, targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled), automatic food stamp eligibility for cash welfare recipients, and modification of the permanent resident requirement so that benefits are available to the homeless. These liberalizations, however, were offset by cost-reduction measures which incuded: Increasing the State responsibility for erroneous payments and an optional State block grant for food assistance. The task force recommendations were heralded by some as a means of restoring full benefits, opening up the program to the new poor (recently unemployed), lessening administrative burdens, and increasing participation among groups in particular need. Critics, however, contended that the task force recommendations did not go far enough in restoring budget reductions previously enacted.

In an April 1985 report on the Food Stamp Program, the General Accounting Office stated that research conducted by private organizations and the U.S. Department of Agriculture [USDA], as well as the President's Task Force on Food Assistance, indicates that many low-income households are not participating in the Food Stamp Program. The GAO said that research studies attributed nonparticipation to such factors as: (1) A lack of information regarding eligibility, (2) the amount of potential aid not being enough to warrant the time and effort to apply, (3) administrative requirements, such as complex application forms and required documentation, (4) physical access problems, such as transportation or the physical condition of the potentially eligible applicant, and (5) attitudinal factors, such as households being sensitive to the social stigma associated with receiving food assistance. Others may feel that they do not need or want Federal food assistance. One study estimated that only 48 percent of eligible elderly received food stamp benefits in 1980 and 1981. Participation was especially low among single elderly individuals, and the older a person was, the less likely he or she was to participate. The author analyzed why eligible elderly persons did not participate in the Food Stamp Program and found that 33 percent of eligible nonparticipants did not think they were eligible for food stamps, and another 36 percent said that they did not know whether they were eligible.

Results of 15 months of research on the problem of hunger in New England, by staff at the Harvard School of Public Health, concluded in 1984, revealed that: (1) Substantial hunger exists in every State in the region; (2) hunger is far more widespread than has generally been realized; and (3) hunger in the region has been growing at a steady pace for at least 3 years, and presently shows no sign of diminishing. The researchers found elderly who are frequenting emergency food programs in greater numbers and that the elderly often suffer in the privacy of their homes, either because it is more difficult for them to get around or because they choose to tolerate their suffering alone, no longer having young children to prompt them to leave their home for food. The doctors also expressed concern over what physicians had noted in their clinical practices: Apparently increasing numbers of malnourished children and greater hunger among their patients, including the elderly. They also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

A January 1986 study by the Harvard University School of Public Health's Physician Task Force on Hunger in America found that food stamps reach less than one-third of the people eligible to receive them in 150 counties across the country. Researchers for the group said that this indicates that hunger is common in many counties across the South, Mid-West, and West. The researchers compared census reports on the number of families under the poverty level with figures on the number of people who receive food stamps. They found that, nationally, the proportion of those eligible to receive them, and those who actually got them, had dropped to 55 percent in 1984 from 65 percent in 1980 and concluded that hunger is increasing as a problem. They also stated that Federal food programs designed to feed the hungry have been weakened and cited as a chief factor, the failure of the Food Stamp Program to reach many people who need its benefits. The Assistant Secretary of Agriculture in charge of the Food Stamp Program disputed the findings, saying that the program served 80 percent of those eligible and that the problem had been overstated because the researchers ignored the seasonal nature of the aid and by improperly equating poverty with hunger.

A study released by Public Voice for Food and Health Policy in February 1986 entitled, "Rising Poverty, Declining Health: The Nutritional Status of the Rural Poor," found that the rural poor were less likely to consume adequate levels of nutrients than were the nonpoor and that rural poor children experienced growth stunting at an alarming rate. Low birth weight rates and infant mortality rates were found to be significantly higher in poor rural counties than in the rest of the Nation. The study also concluded that the rural poor were significantly less likely to participate in most assistance programs.

In late May 1986, the Physician Task Force on Hunger in America released a report entitled "Increasing Hunger and Declining Help: Barriers to Participation in the Food Stamp Program." The major task force conclusions are that while poverty had increased between 1980 and 1985, food stamp coverage of the eligible population has decreased and that program administrative barriers—including lack of information about food stamp rules and "paperwork burdens"—have limited participation among the needy. Critics of the report dispute its claims concerning the rate of nonparticipation, the potential harm to program integrity that might result from adoption of its recommendations, and the accuracy of its identification of some barriers.

According to medical experts on aging, malnutrition may account for a substantially greater portion of illness among elderly Americans than has long been assumed. The concern about malnutrition is rising fast as the numbers of elderly climb and as surveys reveal how poorly millions of them eat. The New York Times reported, in August 1985, that scientists now estimate that anywhere from 15 percent to 50 percent of Americans over the age of 65 consume too few calories, proteins, or essential vitamins and minerals for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in disease resistance seen in elderly patients—a weakening of immunological defenses that has commonly been blamed on the aging process. Experts say that many elderly people fall into a spiral of undereating, illness, physical inactivity, and depression. The recent findings suggest that much illness among the elderly could have been prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold out the promise that many individuals can lighten the disease burden of old age by eating better. Low participation in the Food Stamp Program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

2. REORGANIZATION OF THE FOOD STAMP PROGRAM

The Food Stamp Program is one of the largest and probably the most visible of all Government support programs. It has also been one of the most popular targets of troubled taxpayers and politicians aiming to reduce the size of Government. To opponents, food stamps are a classic case of runway Federal programs—growing from 11.3 million participants in 1971 to 22 million in 1981. Critics label it an income-transfer program unrelated to nutritional needs. It has also been denounced as a breeding ground for fraud and abuse, such as by students and those owning luxury cars and vacation homes. Supporters of food stamps say that it is one of the most effective efforts to combat hunger and proverty in recent years. The food stamp rolls have swelled, they say, not because recipients are abusing the program but because a deteriorating economy (unemployment and inflation) has made more Americans dependent on outside aid.

Many of the criticisms of the Food Stamp Program have resulted in cutbacks since 1981—the Food Stamp Program has been the source of substantial budget savings due to cuts enacted by Congress and administrative changes executed by the administration to limit abuse of the program. Overall, the Congressional Budget Office [CBO] has estimated that legislative measures taken in 1981 and 1982 held food stamp spending for fiscal years 1982 through 1985 nearly $7 billion below what would have been spent under pre-1981 law. This translated into a 13-percent reduction at a time when poverty was at its highest level in nearly two decades. For most recipients, the changes did not lead to a direct reduction in benefits. Rather, they delayed or lowered benefit increases scheduled under previous law. About 1 million people, however, lost eligibility for food stamps due to changes in law, and some recipients received reduced benefits due to administrative changes. As of September 1986, there were 20.5 million food stamp recipients in the United States and Puerto Rico.

(A) THE FOOD SECURITY ACT OF 1985

In late December 1985, the House and Senate reached agreement on a farm bill, and the Food Security Act of 1985, enacted into law (Public Law 99-198) on December 23, 1985. Title XV of the act extends the food stamp appropriations authorization for 5 years, through fiscal year 1990, with dollar limits on appropriations ranging from $13 billion (1986) to $16 billion (1990). It also makes changes in the program that are expected to add about $800 million in new food stamp spending over the next 5 years, plus nearly $300 million to the current $825 million a year nutrition assistance block for Puerto Rico.

Substantial changes affecting the elderly were enacted including:

—automatic food stamp eligibility for AFDC and SSI households (without any special income limit as proposed by the Senate, but not including SSI recipients in California and Wisconsin);

—an increase in the liquid assets limitation for single-person elderly households, from $1,500 to $3,000 (the existing $3,000 limit for households of two or more with an elderly member is not changed, and the limit for nonelderly households is increased from $1,500 to $2,000);

—reinforcement of requirements for food stamp services at Social Security offices;

—expansion of the number of pilot projects allowing the use of simplified application and standardized benefit procedures for AFDC, SSI, and Medicaid recipients; and

—extension of pilot projects for cash payment of food stamp benefits for the elderly.

A number of other new initiatives, benefit increases, and eligibility liberalizations were also passed:

—a requirement for States to establish employment and training programs for employable recipients, with performance standards set by the Federal Government;

—a prohibition on the collection of sales taxes on food stamp purchases;

—an increase in the earned income deduction from 18 to 20 percent;

—an increase in the degree to which high shelter expenses and dependent-care costs are taken into account in food stamp benefit computations;

—an expansion of the definition of "disabled person;"

—more liberal treatment for households with self-employment income;

—liberalization of the rules governing disqualification for failure to meet work requirements;

—liberalization of student eligibility rules;

—a 6-month moratorium on collection of fiscal sanctions from States, coupled with a study of the food stamp quality control system and revision of the system based on the study's results; and

—increases in the nutrition assistance block grant for Puerto Rico.

Benefit reductions contained in the act are:

—earnings received by on-the-job trainees under Job Training Partnership Act programs will be counted as income for food stamp purposes, except in the case of dependents under age 19;

—most rules which disregard the portion of eduction aid not paid for tuition and mandatory fees (i.e., available for living expenses) will be removed;

—most rules which disregard the portion of cash welfare grants diverted through third parties will be removed; and

—in some few cases, those food stamps recipients who also get aid under the Low-Income Home Energy Assistance Act may have limits placed on the extent to which they can reduce their countable income due to utility expenses.

With the enactment of the Food Security Act of 1985, there was no significant executive or legislative consideration of food stamps in 1986. The debate continued over the organization of the Food Stamp Program, however, and the administration did propose reductions in food stamp spending through a variety of means.

(B) THE ADMINISTRATION'S 1986 PROPOSALS

In its February 1986 submission of the fiscal year 1987 budget, the administration proposed substantial changes in food stamp law intended to produce cost savings of $350 million in fiscal year 1987. These revisions, if they had been adopted before May 1986, would have reduced fiscal year 1986 spending by $69 million. They were not, however, agreed to by Congress. They were also estimated to hold the cost of the program in fiscal year 1987 to slightly under the amount presently available for fiscal year 1986. Although the cost of the fiscal year 1987 program was estimated by the administration to be $12.5 billion, the administration requested an appropriation of only $12.3 billion, plus some $66 million in separate budget accounts for Federal administration. The difference ($169 million) was expected to be collected from States owing fiscal sanctions for erroneous benefit payments and used to finance program costs.

The majority of the savings recommended by the administration would arise from proposed repeal of several provisions of the Food Security Act of 1985. These provisions included repeal of: Liberalized limits on liquid assets, the increased earned income deduction, and increased benefits to those with very high shelter costs and those with dependent-care expenses.

Other revisions proposed by the administration are discussed below. The administration felt its proposals were warranted given the pressures on the overall Federal budget and the fact that the core of the Food Stamp Program (existing benefits and inflation increases in benefits) is protected from any automatic spending reductions under Gramm-Rudman-Hollings (The Balanced Budget and Emergency Deficit Control Act of 1985, Public Law 99-177).

(1) Low-Income Energy Assistance Act Recipients

Under existing rules, food stamp households receiving cash assistance for their utility expenses under the Low-Income Energy Assistance Act [LIHEAA] may claim all utility expenses, including the portion indirectly covered by LIHEAA aid, as a shelter expense—thereby potentially reducing their countable income and increasing benefits. Those receiving their LIHEAA aid in the form of "vendor" payment to their utility provider may not claim the portion of their utility bill covered by LIHEAA assistance as a shelter expense. The actual value of the LIHEAA aid is not counted as income to food stamp households, no matter how it is received. The administration proposed to apply the rule now used for vendor-payment recipients to cash-payment recipients, thereby limiting the extent to which they can reduce their countable income due to utility bills. In addition, it proposed to limit the extent to which LIHEAA recipients can take advantage of food stamp "standard utility allowances" by requiring special (and presumably lower) allowances for them.

(2) Job Training Partnership Act Recipients

The Food Security Act required that earnings received by on-the-job trainees in programs under the Job Training Partnership Act [JTPA] be counted as earned income for food stamp purposes, except for dependents under age 19. The administration proposed also to count all other income (e.g., stipends and incentive allowances) received by JTPA participants.

(3) Fulfilling Employment Related Requirements

The Food Security Act required States to establish employment and training programs for food stamp recipients, leaving the design of the program components and much of the decision as to the degree to which recipients would be required to participate to the States. It also allocated increased Federal funding for these efforts, with basic Federal grants escalating from $40 million in fiscal year

1986 to $75 million in later years, plus 50 percent Federal matching for State costs above their share of the basic grant. The administration proposed to substantially remove State control over the degree to which recipients would be required to participate by: (a) Requiring all employable applicants to fulfill job search requirements; and (b) requiring States to place an increasing number of employable recipients in work activities. It also proposed not to increase the basic Federal grants for these employment and training activities as provided in the Food Security Act.

(4) Puerto Rico

In 1986, 1.4 million Puerto Ricans participated in the territory's Food Stamp Program. The Food Security Act allocated additional funding for Puerto Rico's nutritional assistance block grant. Funding would increase from the current $825 million annual level to $853 million in fiscal year 1987, and $937 million by fiscal year 1990. The administration requested only $825 million for fiscal year 1987, and proposed to change the law to remove the additional dollar amounts allocated in the Food Security Act.

(5) State Administrative Funding

Two changes were proposed to reduce Federal costs for State administrative expenses. States with per recipient administrative expenses above 175 percent of the national median would have the Federal share of their administrative costs (generally 50 percent) reduced. Special higher Federal matching rates for anti-fraud and automatic data processing activities would be gradually reduced from 75 percent to 50 percent.

(6) Fiscal Sanctions on States

Under existing law, States are subject to fiscal sanctions for erroneous benefits payments above a tolerance level of 5 percent of total benefits. The sanction is assessed by reducing the Federal share of their administrative costs—generally a 5-percent reduction for each percentage point by which their "error rate" exceeds the tolerance level. The administration proposed to increase the size of the fiscal sanctions by requiring that States pay the actual cost of erroneous benefits above the 5-percent threshold.

(7) Optional Nutrition Assistance Block Grants

As in 1985, the administration proposed to allow States to withdraw from the regular Food Stamp Program, take a block grant of money based on Federal food stamp spending in the previous year, and use the money to operate a food assistance program of their own design. After the first year, a State's nutrition assistance block grant would be adjusted to reflect changes in food prices, unemployment, and other factors judged reasonable by the Federal Government. States could also return to the Food Stamp Program after giving adequate notice.

The administration had advanced this controversial proposal in order to allow States to experiment with potentially more effective and efficient approaches to nutrition assistance, and pointed to a similar recommendation by the 1983–84 President's Task Force on Food Assistance. The adjustable nature of the block grant is intended to ensure, as much as possible, that States do not suffer financially from having chosen to take a block grant rather than continuing to rely on food stamps. Supporters of the block grant concept argue that welfare programs should recognize different community perceptions of need and different standards of living; leaving the decisionmaking to State and local authorities. Moreover, it is argued, turning food aid responsibility over to the States and localities would make for a more "accountable" program, in that States and localities would have a fiscal stake in the program to encourage better administration.

Critics protest that opting States spending within the block grant amount, might be unable to respond adequately to increases in need, given the limited adjustability of block grants. They are also concerned that the broad coverage of low-income households of all types, and the extensive recipient protections built into the Federal Food Stamp Program might be abrogated by States seeking to control expenditures. Some fear that States would opt for a block grant simply to avoid fiscal penalties for high rates of error in operating the regular Food Stamp Program. Finally, some see it as the first step away from a national minimum welfare commitment. Turning over responsibility for food assistance to the States would mean the abandonment of what are, in essence, the only set of nationally uniform minimum welfare standards. With its federally established benefit, eligibility, and administrative standards, the Food Stamp Program has provided an important supplement to what some see as inadequate cash assistance in many States. It has tended to equalize treatment of, and Government benefits to, low-income persons, and has helped liberalize what some perceive as unnecessarily harsh State and local administrative practices in welfare programs.

Given the additional cost and administrative burden of running a separate food aid program, and the substantial overlap between the food stamp population and recipients of other forms of aid, especially cash assistance, it seems probable that turnover of food assistance responsibility to the States would mean the end of food stamps as a separate form of low-income aid and its replacement with re-worked State cash assistance systems.

The administration also proposed a number of less significant administrative changes. Opponents of the President's package of proposed revisions noted that most were specifically rejected in 1985 congressional consideration and saw them as undercutting agreements reached during consideration of the Food Security Act. In any event, as will be seen, the Congress chose not to take consideration of the administration's proposal.

C. LEGISLATION

1. FISCAL YEAR 1987 APPROPRIATIONS

On July 24, 1986, the House approved its version of the fiscal year 1987 appropriations for the Agriculture Department which included food stamps (H.R. 5177). This bill included $12.6 billion for food stamps, plus about $65 million in other budget accounts for food stamp administration. In effect, this appropriations level assumed the administration's projected fiscal year 1987 cost for the program, without any legislative changes ($12.8 billion), added $28 million to ensure that Puerto Rico receives the $853 million allocated to it by the Food Security Act, subtracted the $169 million that the administration assumes will be collected from the States and further reduced the amount by directing that $39 million be transferred to fund the Expanded Food and Nutrition and Education Program. No specific allowance was made for increased funding for employment and training programs under the terms of the Food Security Act of 1985.

On September 1, 1986, the Senate Appropriations Committee reported its version of the fiscal year 1987 agriculture appropriations measure. It included $12.7 billion, plus about $65 million in other budget accounts for Federal administration. It did not include the $39 million transfer to the EFNEP proposed by the House. Final action on fiscal year 1987 food stamp appropriations occurred with the enactment of the fiscal year 1987 continuing resolution (Public Law 99-500) which became law on October 18, 1986. This measure provides the House-recommended appropriation of $12.6 billion, plus about $65 million in other budget accounts for Federal food stamp administration.

2. OTHER LEGISLATION

Food stamps may not normally be used to purchase prepared meals, although exceptions have been provided for elderly participants in meal service programs, drug addicts, and alcoholics in treatment programs, and residents of shelters for battered women and children. At the end of the 99th Congress, amendments were added to the omnibus anti-drug measure (H.R. 5484; as amended in the Senate on October 10, 1986; as amended in the House on October 8, 1986) to allow homeless persons to voluntarily use their food stamps for prepared meals served by public or private nonprofit establishments (e.g., shelters and soup kitchens). These amendments also directed changes in either programs service to the homeless. H.R. 5484, including provisions affecting the homeless, was enacted as Public Law 99-570 on October 27, 1986.

Included in the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) is an amendment that will give States greater leeway in implementing the State Income and Eligibility Verification System [SIEVS] mandated by 1984 amendments to the Social Security Act. SIEVS regulations issued in 1986 require that States match food stamp (and other welfare program) information supplied by applicants and recipients with similar information from the Social Security Administration, unemployment insurance agencies, and the Internal Revenue Service. States must follow up on all inconsistencies within 30 days. The amendment will allow States to follow up on those cases deemed most likely to produce results and extend the time frame for follow up to 45 days. Additionally, as part of the 1986 Immigration Reform and Control Act, Congress has included an amendment that expands verification of eligibility for aliens applying for food stamps (and other welfare benefits) using an automated System for Alien Verification of Eligibility [SAVE].

Existing law and regulations require that the portion of any grant or deferred-repayment loan for post-secondary education going for tuition and mandatory fees not be counted as available income for food stamp purposes. The remainder of the loan or grant is generally to be counted since it is assumed to be used for living expenses (including food). The Higher Education Act Amendments of 1986 (Public Law 99–498) expands that which is not counted as income to include amounts set as allowances for books, supplies, transportation, and miscellaneous personal expenses—in the case of Federal higher education aid.

In the Food Stamp Program, both "gross" and "countable" income affect eligibility and benefit determinations. Gross income is all cash income to a household, less certain "exclusions" provided by law. It is used in determining a household's income eligibility. Households without an elderly or disabled member must have gross monthly income below 130 percent of the Federal poverty levels to be eligible. Low-Income Home Energy Assistance Act [LIHEAA] benefits are excluded by law and, thus, have no effect on a household's gross income eligibility determinations.

Countable income is a household's gross monthly income, less certain "deductions" for living expenses. It is used in determining a household's income eligibility and it is also used in determining a household's food stamp benefit. Because LIHEAA benefits are excluded from the computation of the gross income base, they have no direct effect on countable income. However, because shelter expenses (including utility bills) may, if high enough, qualify a household for an excess shelter expense deduction and thereby reduce countable income, the treatment of utility expenses for which LIHEAA benefits are intended is important.

Under current rules, LIHEAA recipients are treated in a number of different ways with regard to their utility expenses and food stamp determinations. In a number of States under Federal court orders, LIHEAA recipients are allowed to claim, as a shelter expense, the entire amount of their utility bills, regardless of whether the LIHEAA benefit is in the form of a cash payment to the household or a "vendor" payment made to the utility provider. In other States, Federal food stamp regulations are generally followed. These rules allowed LIHEAA recipients getting their benefits as a cash payment to claim the entire amount of their utility costs as a shelter expense, but allow those receiving their benefit as a vendor payment to the utility provider to claim only the protion of costs that they themselves pay.

In 1986, the administration proposed that the law be changed to require that, in all cases, LIHEAA recipients may claim, as a shelter expense, only the portion of their utility costs in excess of LIHEAA aid. The administration argues that LIHEAA recipients should not be able to claim a shelter expense that they do not pay or that is paid out of uncounted income. The Congressional Budget Office and the administration estimate savings from this proposal at about $70 million per year.

Opponents argue that it has always been the intent of LIHEAA to require that LIHEAA benefits not affect food stamps in any way and that the Federal court decisions vindicate this interpretation. The law reauthorization LIHEAA (Public Law 99-425), which was enacted on September 30, 1986, requires that receipt of LIHEAA benefits not affect food stamp eligibility and benefits in any way. It makes clear that the rule used in States under the Federal court decisions is to be applied nationwide, allowing all LIHEAA recipient households to claim the entire amount of their utility costs as shelter expense without regard to whether LIHEAA aid covers them.

Finally, the Food Security Improvements Act of 1986 (Public Law 99-260) provides added time for required studies of the food stamp quality control error rate system mandated by the Food Security Act of 1985. This act was approved by the Senate on March 15, 1986, and an amended version, approved by the House and Senate on March 6, 1986, was enacted on March 20, 1986.

D. REGULATORY AND JUDICIAL ACTION

With one exception, and in expectation of major food stamp legislation, the administration did not pursue significant regulatory changes in 1986. Regulations proposed on March 21, 1986, would significantly change the administrative review procedures used in determining error rates and limiting State appeals of fiscal sanctions, and have come under intense fire. The proposed regulations are intended to limit so-called "arbitration" of contested decisions as to whether particular cases are in error, to limit the degree to which States may argue "good cause" in seeking a waiver of fiscal sanctions, and to change the procedure under which States appeal a decision to take a fiscal sanction. The most substantial of the changes appears to be the proposed change in appeals procedures. Under the proposal, the present food stamp appeals board and various procedures such as hearings would be eliminated and replaced with a decision made by a single Agriculture Department official based on the record submitted to him. The administration argues that the changes are needed to streamline and speed up the appeals process and the process of deciding error rates. Opponents contend that they go too far in removing procedural protections for the States.

The Food Stamp Program differentiates between households that are related and those that are unrelated in determining eligibility and benefits. Related households (or related members of a household) must apply together and have all their income and assets aggregated. An exception is provided for elderly or disabled persons if they can show that they purchase food and prepare meals separately, or are so disabled that they cannot purchase and prepare food separately. Unrelated households or household members may apply separately by showing that they purchase and prepare food separately from other household members, thereby having only their income and assets considered in their application. Aggregating household income and assets tends to lower aggregate household benefits and make eligibility for food stamps less likely due to various program rules; disaggregating household income and assets through separate applications by individual members has the opposite effect. The differentiation between related and unrelated persons was challenged by a related family in court. The Supreme Court upheld the existing rule on June 27, 1986.[1]

E. PROGNOSIS

Many maintain that food stamps have substantially reduced the observed level of malnutrition in the country since the program began its expansion in 1971. The marked improvement in malnutrition and substantially increased food spending suggest that food aid programs may be one of the most effective anti-poverty efforts in the last 15 years. There still remains, however, irrefutable evidence of a significant problem of poverty-related hunger in this country. In 1985, the Food Stamp Program, designed to counteract this problem, faced one of its most severe challenges since its creation. During the 99th Congress, several major food stamp reform bills were introduced, but in the end, efforts to dismantle or dramatically cut the Food Stamp Program were thwarted. No major additional benefit or eligibility limitations were taken up by Congress. Instead, attention focused on reauthorizing appropriations for the program, work and training initiatives, cost-sharing between the Federal Government and States, State flexibility in administering the program, restoring some of the earlier benefit reductions, and easing access to the program. Thus, while no new massive program spending was committed to the Food Stamp Program, Congress recognized that cutting food assistance would be paid back many times by our Nation in the loss of human potential, especially in social and health assistance.

With the enactment of the Food Security Act of 1985, it is unlikely that there will be significant legislative consideration of food stamps in 1987. Deficit reduction pressures, however, may necessitate some congressional attention. And, although food stamps are protected from any automatic spending reductions required by the Gramm-Rudman-Hollings Act (Public Law 99-177), the administration may propose, and Congress may choose, to reduce food stamp spending through other legislation intended to avoid the need for triggering automatic reductions.

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[1] *Lyng, Secretary of Agriculture* v. *Castillo,* 106 S.Ct. 2727 (1986).

Chapter 7

HEALTH CARE

OVERVIEW

The health care challenge to Congress in 1986 was to reconcile the need for substantial deficit reduction with our national commitment to provide America's elderly with access to affordable, high quality health care. Almost every health issue affecting the elderly was framed in terms of its effects on the Federal budget, and the congressional health agenda was acted upon almost exclusively through the annual budget reconciliation and appropriations processes. Yet significant progress was made on a number of important issues related to health care access and quality for older Americans. While the major activity revolved around changes to the Medicare Program, there were also important developments in health services research and training and in responding to the growing problems of the medically uninsured.

A. MEDICARE

1. BACKGROUND

(A) HEALTH CARE COSTS

Prior to the mid-1970's, cost of care was not a major issue among health policy specialists. Instead, expansion of access and the improvement of quality of care were foremost on the Nation's health policy agenda. As costs began to skyrocket, however, concerns began to surface over whether the Nation's health engine was overheated. Between 1965 and 1985, national health expenditures increased from nearly $42 billion or 5.9 percent of GNP to $425 billion or 10.7 percent of GNP.[1] (Figure 1). Even given today's apparent slower rate of increase, health care expenditures could reach $660 billion or more than 11 percent of GNP by 1990, and 14 percent of GNP by the year 2000 (see figure 2).

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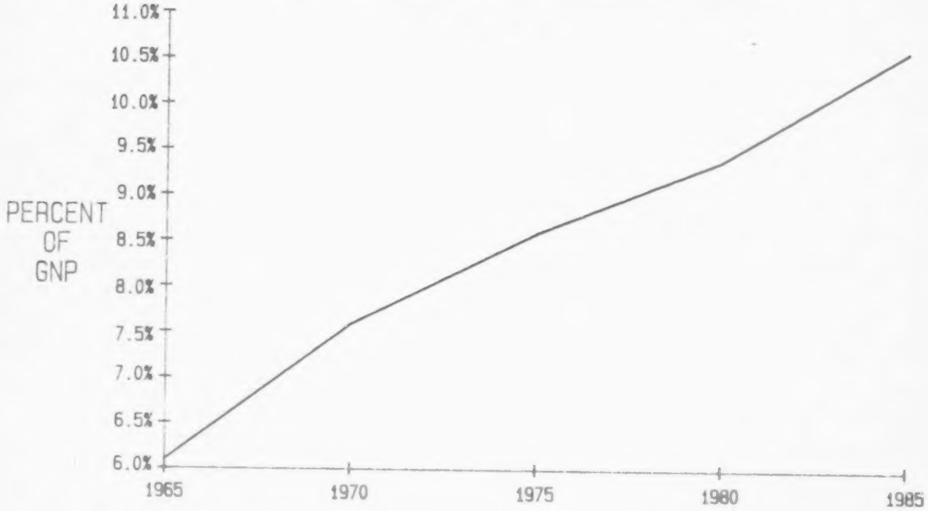
[1] U.S. Department of Health and Human Services. Office of the Actuary, Medical Care Costs, 1985. Washington, 1986.

CHART 7-1

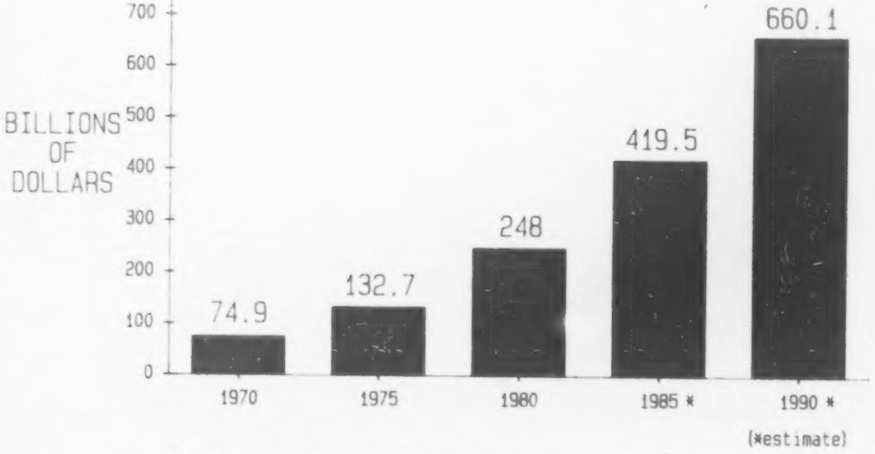
NATIONAL HEALTH EXPENDITURES AS A PERCENT OF GROSS NATIONAL PRODUCT



SOURCE: Health Care Financing Review, Winter, 1984: 1-29 and Fall 1985: 1-35

CHART 7-2

NATIONAL HEALTH SPENDING 1970 - 1990

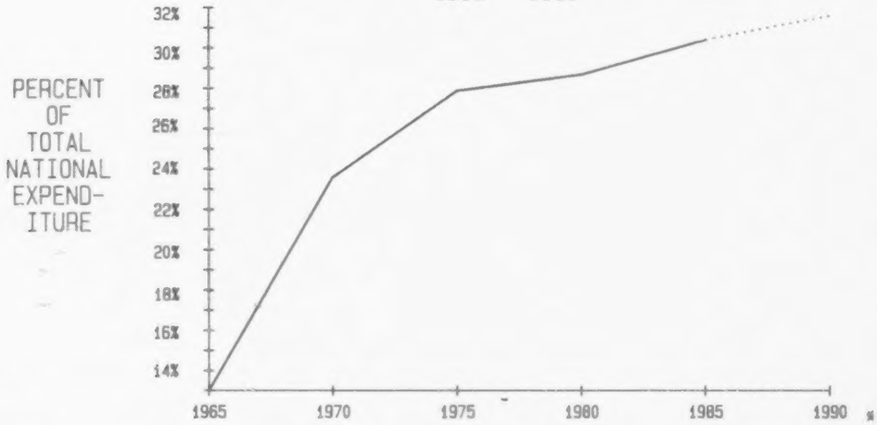


SOURCE Health Care Financing Review, Spring 1985 1-26 and Fall 1985: 1-35

The role of the Federal Government as a payer for health services has grown with the overall increases in health care costs. In 1965, the Federal Government paid just over 13 percent ($5.5 billion) of the Nation's health bill compared to 29 percent ($111.9 billion) of total costs in 1984. Projections of future health bills facing the Federal Government suggest a continued increase in the Federal cost burden exceeding $200 billion, or 32 percent of total costs, by 1990.[2]

CHART 7-3

FEDERAL SPENDING ON THE NATION'S HEALTH
1965 - 1990



SOURCE: Health Care Financing Review, Spring 1985: 1-26 and Fall 1985: 1-35

(*projection)

National expenditures for hospital care and physicians' services exceed expenditures for all other health services combined. Hospital care costs are the single largest component of the Nation's health care bill. In 1985, 39 percent ($167 billion) of the $425 billion spent on personal health care was paid to hospitals. During this same year physicians were paid $83 billion, or 20 percent of total expenditures, the second largest portion of health care spending.[3]

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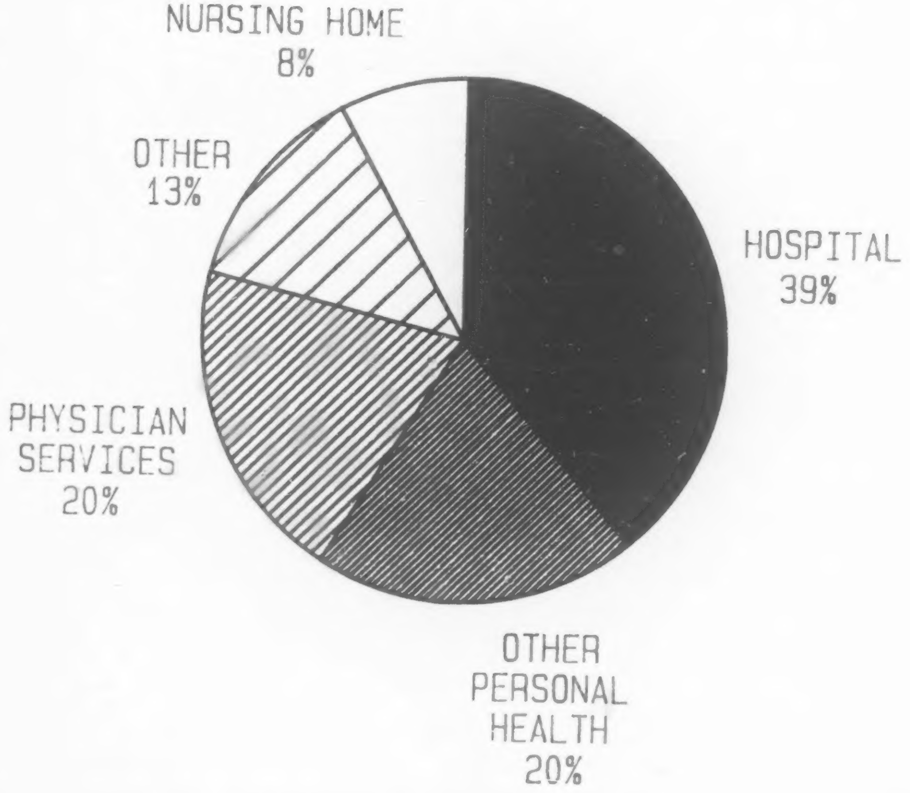
[2] Arnett, Ross H., III et al. Health Spending Trends in the 1980's: Adjusting to Financial Incentives. Health Care Financing Review. Vol. 6 no. 3, Spring 1985.

[3] Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary, HHS News. 1986.

CHART 7-4

WHERE OUR HEALTH DOLLAR WENT IN 1985



SOURCE: U.S. Health Care Financing Administration, Health Care Financing Review, Fall 1986

Throughout the last two decades, the structure and delivery of health care were plagued by perverse incentives, resulting in the overutilization of services, inefficiency and waste. Led by the Federal Government, which was incurring major expenditure increases each year to pay for Medicare, Medicaid, and other health programs, third-party payers began to question whether large scale reform of health care was needed. In 1983, Congress and the administration worked together to achieve the creation of the prospective payment system for Medicare reimbursement of hospitals. This was the most dramatic change in the Medicare Program since it was enacted.

Prospective payment system.—The Medicare prospective payment system [PPS] pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of 471 diagnosis related groups [DRG's] to categorize patients for reimbursement. The amount a hospital receives from Medicare no longer depends on the amount or type of services delivered to the patient; therefore, there are no longer incentives to overuse services. If a hospital can treat a patient for less than the DRG amount, it keeps the savings. If the treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment amount.

In the wake of the 1983 Medicare PPS reforms, States have moved quickly to adopt prospective payment methodologies for their Medicaid Programs. Private payers, too, are advancing a hybrid of reimbursement reforms, ranging from prospective rate setting to innovative capitation schemes. The health care arena is in fact changing rapidly on so many fronts—not just cost containment—that any broad characterization of it today is likely to be outmoded by tomorrow. Nevertheless, it seems a fair generalization to say that the overriding concern influencing the nature of our Nation's health care system is that of cost containment.

Trends in health care inflation.—Looked at in terms of nominal dollars, that is, in dollars not adjusted for inflation, our Nation's cost containment efforts seem to be working. In 1985, the rate of growth in total health care expenditures was 8.9 percent, rising to $425 billion from $390 billion in 1984.[4] This was the lowest rate of annual growth over the past 20 years, dropping below the 10 percent rate of growth achieved during the Economic Stabilization Program in 1973 when some price increases were artificially constrained.

Most analysts attribute the apparent slowdown in health care costs to a number of factors, and not cost containment measures alone. According to the DHHS, the slowdown has also resulted from a low rate of inflation in the economy as a whole, and changing patterns of demand for services, in particular a decline in the use of hospital inpatient services.

It is possible, however, that notwithstanding optimistic reports that cost containment efforts are working, health care expenditures may be escalating faster than in the 1970's. According to Uwe Reinhardt, one of the Nation's leading health economists, we have been fooled into thinking that cost hikes are moderating as a result of "money illusion," that is, the "failure to adjust dollar denominated time services for inflation." In a series of figures, Reinhardt presents disturbing evidence that: (1) "Health care expenditures expressed in constant dollars rose more rapidly after 1980 than they did in the later 1970's;" (2) "Relative to the overall consumer price index, the prices of health services rose much more rapidly after 1980 than they did in the late 1970's." [5]

In figure 5, Reinhardt shows that during 1977-80, nominal health expenditures (not adjusted for inflation) grew at increasing annual rates. However, the constant dollar series shows a declining annual growth rate during that period. But for the period since 1980, the situation is quite the opposite. Since 1980, the annual growth in nominal health outlays has fallen—a trend heralded by DHHS as indicating that health care costs were under control. In fact, the annual growth rate in real expenditures has increased during that period, with the exception of 1984. As Reinhardt says, when viewed in this way, the data support the conclusion that "if it is legitimate to speak of an 'American health-care cost crisis,' that crisis has taken on momentum since 1980 and it has by no means been licked." [6]

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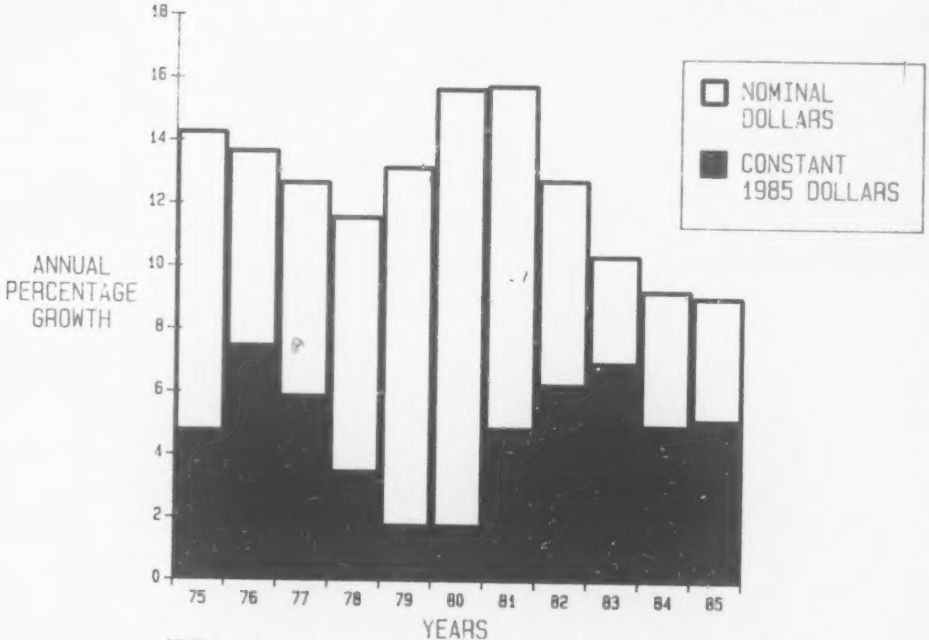
[4] *Ibid.*

[5] Uwe Reinhardt, "How 'Money Illusion' May Have Saved the American Health Sector from Starvation (so far)," 1986, unpublished paper.

CHART 7-5

GROWTH RATES IN NATIONAL HEALTH EXPENDITURES
COMPARISON OF NOMINAL AND CONSTANT 1985 DOLLARS



SOURCE: Uwe E. Reinhardt, "How 'Money Illusion' May Have Saved the American Health Sector from Starvation (so far)," unpublished paper.

While declarations of victory over skyrocketing health care costs may be premature, cost containment efforts continue to dominate our Nation's health agenda, and our Nation's health care system is paying a price for its new lean and mean look. The overriding pressures to reduce costs and make health care delivery more efficient may be succeeding at the expense of reduced access to and diminished quality of health care.

We may in fact be faced with a most difficult tradeoff. Given an economy struggling with high budget deficits, the goals of "unlimited access" and "highest possible quality" are being questioned. This presents us with a dilemma of deciding how, in a period of limited national resources, do we maintain access to the health care system while preserving its quality.

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[6] *Ibid.*, p. 2.

(B) HEALTH CARE UTILIZATION

The health status of the elderly is shaped by a full course of life experiences and health habits. While most older people are basically healthy and report themselves in good to excellent health, many tend not to report specific health problems and mistakenly think they are caused by old age rather than disease. Yet age does affect a person's health, mainly by influencing the way the body reacts to diseases and drugs.

Americans of all ages are healthier today than they were 10 to 20 years ago. However, individual assessment of a person's own health is often the most important measure of health status. Women over age 65 tend to report better health than men do in the same age group. Self-assessed health status is also strongly related to an individual's use of health services.

Chronic diseases are a major threat to the independence of older persons. Arthritis, hypertension, heart conditions, and hearing disorders are leading chronic conditions among the noninstitutionalized elderly. Most older persons who require hospitalization do so for an acute episode of a chronic illness. Visits to the doctor also are most often for treatment of chronic conditions.

The dimensions of the current health service consumption of the aged only hint at future needs. The consumption of health services by the aged is growing because of absolute increases in the total aged population, greater numbers of individuals in the eldest subgroup, and an increased number of services provided per person. Higher expectations for good health, the availability of third-party financing and increased access to certain medical advances (i.e., renal dialysis, radiation therapy) also are prominent among the factors contributing to greater use of health services by the elderly.

(1) Hospital Utilization

Short stay hospital visits by the elderly increased more than 57 percent between 1965 and 1985. Since then, admissions for elderly patients have decreased. In 1985, a survey of non-Federal short stay hospitals revealed that 10.5 million elderly patients were discharged from hospitals; this figure represented 30 percent of all patient stays (table 1). The population 75 and over accounted for 15.7 percent of short stay hospital days. Although the average length of stay has been declining, from 11.1 days for an elderly patient in 1977 to 8.7 days in 1985, older persons tend to remain in the hospital longer than the general population. The hospital discharge rate for those 85 and over was 91 percent higher than that for the 65 to 74 year age group. The average hospital stay for persons age 65 to 74 was about 8 days in 1985 as compared with 10 days for the 85 and over group.

TABLE 7-1.—UTILIZATION OF SHORT-STAY HOSPITALS FOR SELECTED AGE GROUPS, 1985

Age group	Discharged patients			Days of Care			
	Number in thousands	Percent distribution	Rate per thousand	Number of thousands	Percent distribution	Rate per thousand	Average length of stay
All ages	36,056	100.0	147.9	226,217	100.0	954.4	6.5
45 to 64	7,610	21.7	169.5	53,541	23.7	1,192.8	7.0
65 to 74	5,011	14.3	294.9	41,090	18.2	2,417.8	8.2
75 to 84	3,969	11.3	449.8	36,024	15.9	4,082.5	9.1
85 plus	1,528	4.4	563.6	14,612	6.5	5,389.8	9.6
65 plus	10,508	30.0	368.3	91,726	10.5	3,215.1	8.7

Source: National Center for Health Statistics, National Hospital Discharge Survey, 1985.

(2) Use of Physicians' Services

Utilization of physician services increases with age. Approximately four out of five elderly living in the community had at least one contact with a physician in 1983.[7] More than 16 percent of total physician visits during 1983 were made by persons 65 and over. On the average, elderly people are more likely than younger ones to make frequent visits to a physician. Persons 65 and older visit a physician six times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and over reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[8]

Approximately three-quarters of visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, out-patient departments, home and telephone consultations. The higher use of physicians' services by the elderly is associated with their probability of being in poor health. The majority of those who had not seen a physician in 1980 considered themselves in good health.

The aging of the population will create a greater demand for medical care. The need for physician visits will increase by 18 percent (over 30 million visits) by the year 2000, and by 30 percent (over 50 million visits) by 2020. These figures are based on 1980 physician visit rates (153 million visits) and the U.S. Census Bureau population projections.[9]

Because the number of chronic conditions an individual experiences is likely to be greater with advanced age, the health care needs of the elderly are broad in scope and require the participation of a number of health care professionals who are educated in geriatrics and gerontology. In addition to physicians, nurses have substantial responsibilities for providing services to the elderly in a wide range of settings such as hospitals, long-term care settings, ambulatory care programs and day care programs. Dentists, social workers, and allied health care professionals also can actively contribute to the care of the elderly when they are educated about the needs of their older patients.

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[7] Kovar, Mary Grace, Elderly People and Their Medical Characteristics. National Center for Health Statistics, Washington, DC, p. 33.

[8] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, DC, U.S. Govt. Print. Off., 1984-85 edition, p. 77.

[9] *Ibid.*, p. 78.

Available data, however, indicate that only a small fraction of health care professional schools have required curricula in geriatrics and gerontology.[10] In 1984, only 5 to 25 percent of the cadre of competent teachers and researchers who were required to address this need were available.[11]

(3) Use of Disease Prevention Services

Utilization of disease prevention services by the elderly varies by type of service. The majority of the elderly do not seek health services if they perceive themselves to be in good health. The elderly who report that they have not seen a physician within a year, for example, also report that they have no need for physician care.

Elderly persons visit dentists less often than the younger population. Only 35 percent of the 65 and older population visited a dentist in 1981 as compared with 52 percent of the population 45 to 64.[12] At present, older persons do not receive sufficient preventive or therapeutic dental care. It is estimated that almost one-third of the population is likely to lose some or all of their teeth between the ages of 50 and 70; the major cause of loss of teeth is periodontal disease. Studies have shown that improvement in oral hygiene and plaque control is effective in preventing dental and periodontal disease in adults.

Examples of functional impairments that can be corrected or compensated for in the elderly are visual and hearing problems. Yet, these deficits are among the best examples of conditions that older persons often do not seek to remedy. High cost and a lack of Medicare reimbursement discourages many older persons from buying eyeglasses and hearing aids.

Many of the chronic conditions of the elderly are strongly associated with personal health habits. In general, the evidence linking changes in health habits by older persons to reduced risk of disease is fragmentary. A number of behaviors such as diet, exercise, and stress reduction are worthy of the attention of health care professionals because intervention in these areas will have visible positive effects. Appropiate intervention associated with these behaviors will foster a sense of well-being, enhance the self-concept of the elderly, and promote social interaction. The most dramatic example of a behavior change that produces positive effects on health is cigarette smoking, which is a major risk factor in cardiovascular diseases and selected cancers. When a person of any age stops smoking, the benefits to the heart and the circulatory system begin right away. The risk of heart attack and stroke drops and circulation to the hands and feet improves. Nonsmokers also have a lower risk of contracting influenza, pneumonia, and colds. Influenza and pneumonia can sometimes be life-threatening diseases for older persons.

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[10] U.S. Dept. of Health and Human Services, National Institute on Aging. Report on Education and Training in Geriatrics and Gerontology. Washington, DC, U.S. Govt. Print. Off., February 1984, p. 5.

[11] *Ibid.*, p. 51.

[12] U.S. Senate Special Committee on Aging. America in Transition: An Aging Society. Washington, DC. U.S. Govt. Print. Off., 1984-85 ed., p. 78.

(4) Health Care Expenditures of the Elderly

Persons 65 and over, 12 percent of the population in 1985, account for a third of the Nation's total personal health care expenditures.[13] These expenditures represent total health care investment for all sources exclusive of research.[14] Per capita spending for health care in 1985 represented an 11-percent annual growth rate from 1980. Total personal health care expenditures of the elderly were expected to reach $120 billion in 1984 (tables 2-5).

TABLE 7-2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physican	Nursing home	Other care
1984:					
Total per capita	100.00	100.00	100.00	100.00	100.00
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	.4	0.4	.0	.7	.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicare	12.8	4.8	1.9	1.5	11.4
Other government	5.6	9.1	.7	4.4	3.4

TABLE 7-3.—DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY TYPE OF SERVICE AND SOURCE OF FUNDS: UNITED STATES, 1984

Year and source of funds	Total per capita	Type of service				
		Total care	Hospital	Physician	Nursing home	Other care
1984:						
Total per capita	$4,202	100.0	45.2	20.7	20.9	13.2
Private	1,379	100.0	15.7	25.0	33.1	26.2
Consumer	1,363	100.0	15.3	25.3	33.1	26.3
Out-of-pocket	1,059	100.0	5.6	21.4	41.6	31.3
Insurance	304	100.0	49.2	38.6	3.3	8.9
Other private	16	100.0	42.1	1.9	39.1	17.0
Government	2,823	100.0	59.7	18.6	15.0	6.8
Medicare	2,051	100.0	69.2	24.5	.9	5.4
Medicare	536	100.0	17.0	3.1	68.1	11.8
Other government	236	100.0	73.2	2.4	16.5	7.9

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[13] *Ibid.*, p. 79.

[14] *Ibid.*, p. 79.

TABLE 7-4.—PERSONAL HEALTH CARE EXPENDITURES IN MILLIONS FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1984:					
Total	$119,872	$54,200	$24,770	$25.105	$15,798
Private	39,341	6,160	9,827	13,038	10,316
Consumer	38,875	5,964	9,818	12,856	10,237
Out-of-pocket	30,198	1,694	6,468	12,569	9,467
Insurance	8,677	4,270	3,350	287	770
Other private	466	196	9	182	79
Government	80,531	48,040	14.943	12,067	5,482
Medicare	58,519	40,524	14,314	539	3,142
Medicaid	15,288	2,595	467	10,418	1,808
Other guvernment	6,724	4,920	162	1,110	532
Exhibit: Population (in millions)	28.5				

TABLE 7-5.—PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1984:					
Total	$4,202	$1,900	$868	$880	$554
Private	1,379	216	344	457	362
Consumer	1,363	209	344	451	359
Out-of-pocket	1,059	59	227	441	332
Insurance	304	150	117	10	27
Other private	16	7	1	6	3
Government	2,823	1,684	524	423	192
Medicare	2,051	1,420	502	19	110
Medicaid	536	91	16	365	63
Other government	236	172	6	39	19

Source: Waldo, Daniel R., Lazenby, Helen C.; Demographic Characteristics and Health Care Use and Expenditures by the Aged in United States: 1977–84, "Health Care Financial Review," vol. 6, No. 1, fall 1984.

(5) Health Care Expenditures by Source

(a) Hospital

Hospital care for the aged was projected to cost $54 billion in 1984; this is an amount equal to $1,900 per capita. Medicare reimbursement will account for three-quarters of that amount; other sources of public funds will pay about 15 percent of the bill. Private health insurance will cover 8 percent of the costs; the remaining 3 percent will be paid out-of-pocket.[15]

(b) Physicians' Services

Spending for physician services to the elderly grew an average of 18 percent per year from 1977 to 1984, reaching a projected level of

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[15] Waldo, Daniel R. and Helen C. Lazenby. "Demographic Characteristics and Health Care Expenditures by the Aged in the United States: 1977-1984." Health Care Financing Review. Vol. 6, No. 1, Fall, 1984, p. 12.

$24.8 billion for 1984.[16] The growth in patient days spent in the hospital by the elderly (3 percent increase per year during the period 1977–83) largely accounts for the increase in physician services and costs.[17]

(C) MEDICARE PROGRAM DESCRIPTION

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In 1985, Medicare insured nearly 27 million aged and 3 million disabled individuals. At a 1986 estimated cost of $71 billion, Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

As insurance for short-term acute illnesses, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services. Medicare does not cover the hospital costs of extended acute illnesses, however, and does not protect beneficiaries against potentially large co-payments or charges above the Medicare payment rate for physician services. These shortcomings in Medicare's coverage of the costs of acute illness have led two-thirds of older Americans to purchase supplemental private coverage, often referred to as medigap coverage.

Medicare (authorized under title XVIII of the Social Security Act) is a nationwide program that provides health insurance protection to most individuals age 65 and over, to persons who have been entitled to Social Security or railroad retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the Hospital Insurance Program (part A), and the Supplementary Medical Insurance Program (part B).

(1) Hospital Insurance (Part A)

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During calendar year 1986, each worker and employer paid a tax of 1.45 percent on the first $42,000 of covered employment earnings. The self-employed paid both the employer and employee shares.

In 1985, Hospital Insurance [HI] payroll taxes amounted to $47.6 billion, accounting for 92.6 percent of all HI income. Interest payments to the HI fund equalled 6.5 percent of all HI income for 1985. The remaining 0.9 percent of 1985 income consisted primarily of transfers from the Railroad Retirement Account and the general fund of the Treasury, and premiums paid by voluntary enrollees. Of the $48.4 billion in HI disbursements, $47.6 billion was for benefit payments while the remaining $0.8 billion (1.7 percent) was spent for administrative expenses. In 1985, the HI trust fund was credited with an additional $1.8 billion, representing a partial repayment of the interfund loan made to the Federal Old-Age and Survivors Insurance Trust Fund in December, 1982.[18]

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[16] *Ibid.*, p. 13.

[17] *Ibid.*, p. 13.

During each benefit period (defined as beginning when an insured person enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for 60 days), part A pays for:

(1) Ninety days of inpatient hospital care, subject to a deductible ($492 in calendar year 1986; $520 in calendar year 1987); and a daily copayment ($123 in 1986; $130 in 1987) that is required for the 61st day through 90th day. An additional lifetime reserve of 60 days, subject to a daily copayment ($246 in 1986; $260 in 1987) may be drawn upon when an individual exceeds 90 days in a benefit period. Both the deductible and copayment amounts are adjusted annually;

(2) One hundred days of post-hospital skilled nursing facility [SNF] care, which are subject to a daily copayment ($61.50 in 1986; $65 in 1987) after the first 20 days;

(3) Home health care is provided on a part-time or intermittent basis. There is no specified limit on the number of visits and no copayment is required;

(4) Hospice services for the terminally ill are also covered. A beneficiary may elect to receive services for two 90-day periods and one subsequent 30-day period during his or her lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. This election may be revoked.

Hospital reimbursement under Medicare is now in transition from the original retrospective cost-based reimbursement method of payment to a prospective system of payment rates based on diagnosis related groups [DRG's]. Under PPS, hospitals are paid a set price for each case, as classified into 471 DRG's. The phase-in of prospective payment by DRG rates began in October 1983 and is scheduled for completion October 1, 1987.

(2) Supplementary Medical Insurance (Part B)

Part B of Medicare, supplementary medical insurance (SMI), is a voluntary program financed jointly through monthly premium charges ($15.50 in 1986; $17.90 in 1987) on enrollees and Federal general revenues. Premiums cover 25 percent of program costs; 75 percent are funded from general revenues. Part B (with certain exceptions) pays 80 percent of reasonable charges for the following covered services after the insured meets a $75 deductible: physician and other professional services, diagnostic tests, medical devices, outpatient hospital services, and laboratory services.

In 1985, 29.9 million people were covered under SMI. General revenue contributions equalled $18.3 billion, accounting for 72.7 percent of all income. Another 22.4 percent of all income resulted from premiums paid by participants, with interest payments to the

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[18] U.S. Department of Health and Human Services, Health Care Financing Administration. 1986 Annual Report of the Board, of Trustees of the Federal Hospital Insurance Trust Fund. Washington, March 31, 1986, p. 2.

SMI fund accounting for the remaining 4.9 percent. Of the $23.9 billion in SMI disbursements, $22.9 billion were for benefit payments while the remaining $0.9 billion (3.9 percent) were for administrative expenses.[19]

Physician reimbursement.—Medicare pays physicians the "reasonable charge rate" for their service, less the deductible and the copayment. The reasonable charge for a service is the lowest of three dollar amounts: (1) the physician's actual bill for the service; (2) the amount which the physician usually charges for the service; or (3) the usual charge made for this service by all physicians in the same locality. Under the Deficit Reduction Act of 1984 (DEFRA, Public Law 98-369), physician fees were frozen under Medicare for the 15-month period, July 1, 1984, through September 30, 1985. Public Law 99-107, as amended, and COBRA (Public Law 99-272) extended this freeze through April 30, 1986, for participating physicians and December 31, 1986, for nonparticipating physicians.

DEFRA established the concept of the participating physician. The participating physician is one who voluntarily enters into an agreement with the Secretary to accept assignment for all services provided to all Medicare patients for a future 12-month period.

Participating physicians were subject to the first 15-month freeze. They were, however, permitted to increase their billed charges during the freeze period. While increases in billed charges did not raise Medicare payments during the freeze period, these charges were to be reflected in the calculation of future customary fee screen updates. DEFRA included additional incentives for physicians who agreed to become participating physicians. These included the publication of directories identifying participating physicians and the maintenance by Medicare carriers of toll-free lines to provide beneficiaries with names of participating physicians. As of May 1986, 28.3 percent of physicians were "participating."

Since the enactment of DEFRA, nonparticipating physicians (i.e., those who have not signed a voluntary participating agreement) could continue to accept assignment on a case-by-case basis. They could not, however, increase their billed charges during the freeze period over the amounts charged for the same services during the April 1, 1984, through June 1, 1984 period. The law required the Secretary to monitor charges of nonparticipating physicians to determine compliance with the fee freeze. Nonparticpating physicians who did not comply with the freeze were subject to civil monetary penalties or assessments, exclusions for up to 5 years from the Medicare Program or both.

Besides extending the period of the physician fee freeze, COBRA (Public Law 99-272) made a number of changes in the Medicare physician reimbursement law. As a result of COBRA, on May 1, 1986, participating physicians received an increase in prevailing charges based on the Medicare economic index [MEI] for 1986 plus an additional 1 percentage point. The 1 percentage point increase would be discontinued after December 31, 1986. In addition, participating and nonparticipating physicians would receive a prevailing charge increase each year beginning January 1, 1987. The increase for nonparticipating physicians would be lagged and would be based on the MEI for the preceding year.

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[19] U.S. Department of Health and Human Services, Health Care Financing Administration. 1986 Annual Report to the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund. Washington, March 31, 1986, p. 2.

COBRA also required the Secretary, with the advise of the newly established Physician Payment Review Commission, to develop a relative value scale for physician payments. The Secretary was required to complete the development of the RVS and report to Congress by July 1, 1987, and was to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

In addition, COBRA made some changes in the law relating to the publication of directories of participating physicians. It also required that each explanation of benefits provided to beneficiaries in conjuction with the payment of claims on other than an assigned basis include a reminder of the participating physician and supplier program, including the limitation on charges that may be imposed, and the toll-free number or numbers at which an individual enrolled under part B of Medicare can obtain information on participating physicians and suppliers.

In OBRA (Public Law 99-509), Congress again provided for a number of changes in the way Medicare reimburses physicians, adding yet a new layer of complexity to an already extremely complicated payment system. (See Legislation.) OBRA provides that Medicare give both participating and nonparticipating physicians a 3.2 percent update in prevailing charge levels beginning January 1, 1987. For fee screen years beginning on January 1, 1987, prevailing charges for nonparticipating physicians will be set at 96 percent of the prevailing charge levels allowed participating physicians. The freeze on actual charges of nonparticipating physicians, which ended December 31, 1986, is replaced by the following system of charge limits, effective January 1, 1987:

> January 1, 1987—charge increases are limited to one-quarter of the difference between the actual charge and 115 percent of the Medicare prevailing charge;
>
> January 1, 1988—charge increases are limited to one-third of the difference between the actual charge and 115 percent of the Medicare prevailing charge;
>
> January 1, 1989—charge increases are limited to one-half of the difference between the actual charge and 115 percent of the Medicare prevailing charge; and
>
> January 1, 1990, and subsequent years—the actual charge may be increased the remaining amount necessary to reach 115 percent of the Medicare prevailing charge.

The base period used for determining the maximum allowable actual charge for nonparticipating physicians in 1987 will continue to be the physician's actual charges for the period April through June 1984. There are special rules for those physicians who do not have actual charges for that period of time.

(3) Peer Review Organizations

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] replaced the existing Professional Standards

Review Organizations [PSRO] program with a utilization and quality control peer review program. The Secretary of Health and Human Services was required to enter into performance-based contracts with physician-sponsored or physician-access organizations known as peer review organizations [PRO's] by November 1984. Hospitals receiving payment under the new prospective payment system were required to enter into an agreement with a PRO under which the PRO would review the validity of diagnostic information provided by the hospitals; the completeness, adequacy, and quality of the care provided; the appropriateness of admissions and discharges; the accuracy of coding to assure that payments were appropriate for the diagnoses and procedures associated with the stay; and the appropriateness of payments for outlier cases (i.e., cases which are extraordinarily costly to treat based on cost and length of stay criteria). In addition to reviewing cases for quality and utilization concerns, PRO's had individual quality and utilization objectives to achieve that were negotiated to meet specific problems in their local areas.

PRO's are evaluated by the HCFA regional offices, HCFA central office, and an independent contractor. The Office of the Inspector General has also performed audits and inspections of various aspects of the PRO program. Where problems are found by HCFA, the PRO is required to develop and follow through on a corrective action plan. If HCFA is not satisfied with the plan, it may terminate its contract with the PRO, and find a new organization with which to contract. In the first 2 years of the PRO program, contracts were terminated in three States: Pennsylvania, South Carolina, and Massachusetts.[20]

In early 1986, the Department of Health and Human Services released a new "scope of work" to govern PRO operations for the second contract period. Under this new work plan, the emphasis on quality has been increased by: (a) Providing for generic screening criteria as a tool for identifying potential quality problems; (b) requiring each case selected by the PRO for review to be reviewed for the appropriateness of the discharge; and (c) broadening the scope of PRO objectives to better address quality issues. Review will be more focused, providing for intensified review of unacceptably performing hospitals. In addition, each PRO will also be required to have a community outreach program to educate beneficiaries about PRO review and their Medicare rights.[21]

PRO contracts for the first 2 years expired between June 30 and November 14, 1986. As of late 1986, 48 new contracts had been successfully negotiated, with almost all of them going to the same organizations that held the original contracts. The largest awards were given to California, New York, Texas, Illinois, and Florida.

According to HCFA, PRO utilization review saved the Medicare Program about $174 million in the first 2 years. Another $17 million was saved as a result of PRO review of DRG coding. HCFA also states that Medicare hospital admissions decreased 5 percent on a national average. Overall, HCFA concludes that the cost-benefit ratio for the PRO program is 1.2: 1, not including an allowance for any sentinel effect.[22]

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[20] Department of Health and Human Services, HCFA 1986 Report to Congress on the PRO's, September 1986.

[21] *Ibid.*

(4) The HMO Benefit

During 1982 and 1983, DHHS awarded 26 Medicare demonstration-program contracts to develop Medicare HMO's. These demonstration projects, which were operational in 21 cities across the country, were implemented to test whether the HMO concept would be effective in holding down Medicare health expenditures. Final regulations implementing nationwide expansion of the program were published on January 10, 1985, and in February 1985 the Department initiated the program providing for the expanded use of HMO's by Medicare.

Two kinds of organizations are now eligible to contract with Medicare: Federally qualified HMO's under the 1973 HMO Act and competitive medical plans, CMP's, as defined in the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA]. CMP's include any organization which provides a minimum range of Medicare services through physicians who are employers, partners, or contractors.[23] This category of plans was created to broaden participation and to stimulate competition in the medical marketplace.

Under TEFRA, Medicare pays participating organizations prospectively for services rendered. HMO's signing a "risk" contract have agreed to provide all defined services at risk to the organization. In other words, the HMO is responsible for any cost overruns. The beneficiary who enrolls in a risk contract HMO must receive all medical services except for emergency or urgently needed services from that HMO. This feature is referred to as the "lock-in" provision. Beneficiaries are responsible for services received "out-of-plan" or those services that have not been authorized by the HMO. Neither the HMO's nor regular Medicare are responsible for payment of out-of-plan services. The formula used to determine the amount of payment per Medicare beneficiary is referred to as the average adjusted per capita cost, or AAPCC. The payment made to the HMO is equal to 95 percent of the AAPCC or what Medicare estimates it would have paid traditional providers (hospitals and fee-for-service physicians) in the same community, thus saving Medicare 5 percent on each Medicare HMO enrollee. HMO's are also permitted to charge beneficiaries a monthly premium equal to the value of traditional Medicare deductibles and copayments.

As of September 1986, there were 875,000 Medicare beneficiaries enrolled in both risk and cost contract HMO's, or about 3 percent of the total Medicare population. One hundred and forty-three risk and 41 cost contracts had been signed. Another 54 risk contract applications were pending.[24]

The Reagan Administration wants the current risk contract method of reimbursement to be a stepping stone toward a voucher system in which a set amount of cash payment would be provided to each beneficiary to be used to purchase health coverage from the private market. The theory behind the administration's voucher plans is to allow the beneficiary to purchase health insurance using marketplace choices available to the general public. Most recently, the administration has been promoting a revised voucher plan that would pay insuring organizations, such as an insurance company or a major employer or union, on a capitated amount to promote health insurance for Medicare beneficiaries in that organization. The difference between this new plan and the traditional voucher proposal is that the organization rather than the individual would receive the capitated payment. This incentive for competition and consumer choice has been called the "cornerstone" of the domestic policy agenda by top administration officials.[25]

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[22] *Ibid.*

[23] Iverson, Laura Himes and Cynthia Polich. The Future of Medicare and HMO's. Excelsior, MN, Interstudy 1985, p. 10.

[24] U.S. Government, Health Care Financing Administration, Summary of TEFRA Risk Contracts as of September 30, 1986. Washington, 1986.

(D) SUPPLEMENTAL HEALTH COVERAGE

From its enactment, Medicare was never intended to cover its beneficiaries' total health care expenditures; several types of services are not covered at all, others are covered to some extent but require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare has consistently covered approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered by Medicaid, private supplemental health insurance, and other sources.

According to HCFA's National Medical Care Utilization and Expenditure Survey of 1980, 67 percent of the aged Medicare population has private insurance in addition to Medicare. Of the $41.7 billion in total medical expenses incurred by noninstitutionalized aged Medicare beneficiaries in 1980, Medicare paid 56 percent, patients and their families paid 18 percent, Medicaid paid 7 percent, and private insurance plans paid 15 percent. The likelihood of having private insurance in addition to Medicare increased among those with more education, and those with higher family incomes. Among the Medicare beneficiaries who had private insurance coverage, 82 percent had one private insurance plan, 17 percent had two or more, and 3 percent had three or more. Approximately 54 percent of the aged Medicare beneficiaries with private insurance had Blue Cross/Blue Shield plans, 45 percent had commercial insurance, and 6 percent were enrolled in HMO's or other prepaid health plans.

Private insurance purchased by the elderly generally concentrates its coverage on services which are covered by Medicare. For instance, in 1977, 97.6 percent of all privately insured elderly persons with Medicare coverage had supplemental coverage for hospital inpatient services, and 60 percent had coverage for ambulatory physicians' services, outpatient diagnostic services, and care in skilled nursing facilities. On the other hand, relatively few Medicare beneficiaries had private insurance which covered services excluded from Medicare coverage: Only 40.6 percent had coverage for medicines prescribed outside the hospital, and only 4.1 percent had any dental coverage.

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[25] Firshein, Janet. "HCFA Links Medicare's Future With Capitation." Hospitals, August 5, 1986, pp. 63-64.

Group insurance often provides major medical coverage, requiring a substantial deductible but offering comprehensive coverage of remaining expenses. By contrast, about 75 percent of the elderly with individually purchased insurance held no major medical benefits. Group policy benefits were also superior to nongroup insurance in their coverage of fees exceeding the Medicare allowable charge. Group health insurance offers premium advantages, as well as coverage advantages, to the Medicare population. This is possible largely because employers help make group insurance affordable.

Section 1882 of the Social Security Act, added by Public Law 96-265, June 9, 1980, established standards for Medigap policies requiring that they provide at least a minimum level of benefits. This was accomplished through the use of loss ratios—minimum expected levels of benefit payouts. Medigap policies sold to individuals must have an anticipated return to policyholders as benefits of at least 60 percent of the premiums collected. This mimimum loss ratio was set at 75 percent for policies sold to groups. In addition, section 1822 established Federal criminal penalties for engaging in abusive sales and marketing practices for Medigap policies.

The statute incorporated by reference the model regulatory program of the National Association of Insurance Commissioners, setting forth two procedures for determining whether insurance policies meet the Federal standards. First, the statute established that if a State has adopted laws or regulations that are at least as stringent as the association's model and the Federal loss ratio requirement, policies regulated by the State are deemed to meet the Federal requirements. Second, the statute established a voluntary certification program under which insurance companies could market policies as Medigap insurance in States that do not have laws or regulations equivalent to the association's model. Under such a system, insurers can submit policies and supporting documentation to the Secretary of Health and Human Services [HHS]. If the Secretary determines that a submitted policy meets Federal requirements, it is certified and can be marketed as Medigap.

According to a GAO study of the Medigap market,[26] all but four States had adopted Medigap insurance regulatory programs at least as stringent as the Association of Insurance Commissions by September 1986. This has resulted in more uniform regulation of Medigap insurance and increased protection for the elderly against substandard or overpriced policies. Most large commercial insurers, with premiums of $50 million or more, met the loss ratio requirements of section 1882. However, over 60 percent of the commercial insurance policies with premiums under $50 million did not meet those requirements. The aggregate figures for all individual policies studied by the GAO showed that about 60 cents of every premium dollar was returned as benefits or added to reserves.

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[26] U.S. Government, General Accounting Office, Report to the Subcommittee on Health, House Committee on Ways and Means, "Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies." October 1986.

Of 142 policies studied by the GAO, the loss ratios of most policies were below the section 1882 targets; however, the loss ratios of both Blue Cross/Blue Shield plans and Prudential Life Insurance were usually above the targets. This is important because these are the policies most commonly purchased. The Blue/Cross Blue Shield plans had an aggregate loss ratio of 81.1 percent in 1984; the Prudential plans had a loss ratio of 77.9 percent in 1984.

While the loss ratio is a useful guideline to determine if the level of benefit payout is adequate, it is not a requirement. Thus, according to DHHS's interpretation of the law, States are not required to monitor loss ratio experience. Furthermore, penalties for Medigap sales abuse have been seen as the prerogative of the States because they are primarily responsible for regulating the insurance industry. All States GAO visited had a formal complaint system, within either the State insurance department or the State department of elderly affairs. And, all States GAO visited also monitored the advertising practices of insurance companies. GAO concluded that section 1882, when combined with State efforts, not only was protecting the elderly against substandard Medigap policies, but also was providing them with information on how to select Medigap policies. This conclusion has been criticized by some consumer organizations, including Consumers Union.

2. Issues

(A) MEDICARE SOLVENCY AND COST CONTAINMENT

Total costs for Medicare have steadily increased since the program was enacted. Outlays for both benefits and administrative expenses increased from $4.6 billion in 1967 (the first full year of the program) to an estimated $73 billion in 1986. By 1990 Medicare outlays are expected to reach over $100 billion.

The rise in Medicare costs has been a concern on two levels. First, Medicare has been consuming an increasing share of the Federal pie. In 1986, expenditures on Medicare represented 7.4 percent of the total Federal budget. This compares with a little over 4 percent in fiscal year 1976. With Federal deficits expected to remain above $150 billion in fiscal year 1987, there are strong pressures to curb the growth in Medicare outlays. As the second most expensive domestic program, it provides a major target for deficit reduction efforts. While part A is largely funded out of the hospital insurance trust fund and should be, in the view of many in Congress, taken out of the unified budget, part B is largely funded out of general revenues. It is thus a prime target for annual spending cuts. By law, only 25 percent of the SMI Program is financed by premiums paid by beneficiaries. The bulk of SMI goes to pay for physician services. Thus as physician payments increase, so too will pressures on the general treasury to finance part B—a fact that has underscored the need to bring effective cost containment to physician and other part B expenditures.

A second driving force for Medicare cost containment is the need to assure solvency of the hospital insurance trust fund. The introduction of PPS, along with other factors slowing inflation in the medical marketplace, has given new life to the trust fund. In 1984, the Medicare trustees were estimating that the HI fund would go bankrupt by 1989 under pessimistic economic assumptions and 1992 under intermediate economic assumptions. In the 1985 report, the trustees revised their projections, estimating that the HI trust fund would remain solvent until 1998 under intermediate economic assumptions, and 1992 under pessimistic ones. In the 1986 report, the trustees again revised their projections, moving forward the date of insolvency under intermediate assumptions to 1996, but 1993 under pessimistic assumptions.

In light of the 1986 projections, there remains a legitimate concern that the present financing schedule for the HI trust fund is inadequate to ensure its long-term health. According to the trustees, "in order to bring the HI trust fund into close actuarial balance for the first 25-year projection period under alternative II-B assumptions (intermediate economic assumptions), either outlays will have to be reduced by 22 percent or income increased by 28 percent.[27] Moreover, because of changing demographics, there will be increasingly fewer workers to support each Medicare beneficiary as we move into the next century. Today, there are four covered workers supporting each Medicare HI enrollee. By the middle of the next century, there will be only slightly more than two covered workers supporting each enrollee. According to the trustees, "Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all but the most optimistic assumptions, the HI trust fund is projected to become exhausted even before the major demographic shift begins to occur.[28] Thus, there is a pressing need to build reserves now to ensure the same level of benefits to the next generations of elderly.

Impact of past cost containment efforts.—Some progress has been made toward lowering future costs and ensuring the solvency of Medicare. According to HCFA's 1984 report on the impact of PPS on Medicare, PPS "appears to have slowed the increase in Medicare inpatient hospital payments. Although the increase is still above the general rate of inflation, it appears to represent a downturn in the rapid growth of inpatient hospital payments that was seen as a major threat to the solvency of the Medicare Trust Funds. The estimated real rate of growth (i.e., the rate of growth after adjustment for the overall rate of inflation) in Medicare inpatient hospital payments in fiscal year 1984 was 3.8 percent, compared to the annual 10 percent real rate of increase between fiscal year 1973 and fiscal year 1982."[29]

HCFA also indicated that the rate of growth of Medicare outpatient hospital payments was lower in 1984 than in previous years, increasing about 7.3 percent. Physician payments also grew at a slower rate: 6.2 percent as compared to an annual 8.9 percent real rate of increase between fiscal year 1973 and fiscal year 1982. HCFA stated that it did not know the degree to which this drop was attributable to the freeze on physician payments.[30] Data from the latter part of 1985 and 1986 suggest that the effects of cost containment strategies may be more mixed than those revealed in the first post-PPS data and that in fact, Medicare may be experiencing more cost-shifting than cost containment. For the first quarter of fiscal year 1986, total Medicare hospital payments were 4 percent less than for the first quarter of fiscal year 1985. However, total outpatient benefits were 59 percent higher, reflecting higher outpatient hospital, other outpatient services, home health and skilled nursing benefits.[31]

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[27] U.S. Department of Health and Human Services, Health Care Financing Administration, 1986 Annual Report to the Trustees of the Federal Hospital Insurance Trust Fund. Washington, March 31, 1986, p. 50.

[28] *Ibid.*, p. 51.

[29] U.S. Department of Health and Human Services. Report to Congress: "The Impact of the Medicare Hospital Prospective Payment System, 1984." Washington, DC, p. xvii.

[30] *Ibid.*

Future reforms needed.—In working out the means to prevent the future insolvency of the trust fund, Congress may have to make further systemwide changes to the Medicare Program. There is however, no consensus at this time about how reform is to be achieved. Some, for example, advocate tapping new sources of revenue for the trust fund such as additional premiums, an income tax surcharge to be paid by Medicare beneficiaries, dedicated additional excise taxes on tobacco and alcohol, and funds from general tax revenues. Others propose to transform the basis mode of health care delivery to a delivery system dominated by organizations that manage the provision of health care, such as health maintenance organizations and competitive medical plans. Still others suggest that Medicare costs can be contained by cutting back coverage, by requiring a means test for eligibility, or by altering payment incentives to make providers more efficient.

Cost containment and cost-shifting.—While there has always been a certain degree of cost-sharing and cost-shifting in the Medicare Program, the problem has worsened with Federal cost containment efforts. Medicare was not designed to provide beneficiaries with comprehensive health benefits; preventive health care, long-term care and prescription drugs are just some of the areas not covered that have to be paid for by the beneficiary either through supplemental insurance coverage or out-of-pocket. In addition, "shortfalls in Medicare . . . reimbursement of doctors and hospitals have led health care providers to shift unreimbursed costs of serving uninsured patients and Government beneficiaries to private sector bill payers."[32]

As cost containment and budget battles have taken their toll on Medicare, beneficiaries have been forced to pay for a higher proportion of costs of their health care. ICF, Inc., a private consulting firm, prepared an analysis for the American Association of Retired Persons on the role of Medicare in financing the health care of older Americans.[33] ICF found the following:

—The average elderly household will incur health expenditures (including health insurance premiums) of approximately $8,340 in 1986.

—Medicare will pay for almost 40 percent of household costs, and 45 percent of the average individual's costs. Medicare will pay for almost 60 percent of the costs of noninstitutionalized elderly and only about 20 percent for the elderly who are institutionalized.

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[31] U.S. Department of Health and Human Services, Health Care Financing Administration, Report on PPS Monitoring Activities, Memorandum, April 15, 1986, p. 6.

[32] Meyer, Jack A. "Passing the Health Care Buck: Who Pays the Hidden Cost," with William R. Johnson and Sean Sullivan. Washington, DC, American Enterprise Institute for Public Policy Research, 1983, p. 1.

[33] ICF, Inc., "The Role of Meidcare in Financing the Health Care of Older Americans, "July 1986, Washington, DC.

—The average elderly household will pay approximately $2,670 for direct out-of-pocket payments and health insurance premiums.

—As a percentage of household income, the average elderly household will pay 11.6 percent of income on direct out-of-pocket payments and health insurance premiums in 1986.

In 1986, it is estimated that non-Medicare covered health care expenditures for prescription drugs for the noninstitutionalized elderly were $8.5 billion. The noninstitutionalized elderly spent a total of almost $10 million on dental care, eyeglasses, and other professional and health services.

(B) QUALITY OF CARE

When Congress enacted Public Law 98–21 establishing Medicare's prospective payment system, there was a general recognition that inherent in the newly structured payment system were incentives to underserve patients and discharge patients prematurely. To ensure against these outcomes, Congress charged the peer review organizations with monitoring for quality of care as well as utilization outcomes.

Nevertheless, PPS incentives to reduce costs and thus services were strong enough to raise fears that the health or lives of some Medicare beneficiaries would be endangered. After a year of implementation, many physicians and consumer groups representing the elderly began to grow concerned that PPS was posing serious threats to quality for care of Medicare beneficiaries, and might be eroding access to care for the sickest and oldest beneficiaries.

In December 1984, the American Medical Association published the results of an informal survey of its members. A large majority of those who responded felt quality of care had already deteriorated, or would deteriorate as a result of PPS. The AMA survey reported that hospital administrators were encouraging physicians to discharge patients for a primary condition and readmit for a second; that there was pressure to release patients prematurely; and that practitioners were being asked to take a more critical look at the number of tests and procedures that they were ordering for their patients.

In February 1985, the General Accounting Office released a preliminary report of a study it was conducting on the impact of PPS on post-hospital care for Senator Heinz and the Special Committee on Aging. The GAO report,[34] based on testimony from hospital, nursing home, and home health agency representatives from six communities around the Nation, indicated that patients were being discharged from hospitals "sicker and quicker" than before PPS and that in too many cases, were being discharged to inappropriate levels of care or to no care at all. These findings were echoed in a joint hearing of the House Select Committee on Aging and the Task Force on Rural Elderly on February 26, 1985.

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[34] U.S. General Accounting Office, "The Impact of Medicare's Prospective Payment System on Post-Hospital Care." Letter of February 21, 1985, to Senator John Heinz, Washington, DC, 1985.

The administration, through the Health Care Financing Administration, countered these findings by claiming that "while there have been isolated instances of premature discharge and inappropriate transfer, there has been no evidence of systemic abuse."[35] HCFA argued that the watchdogs of quality, the PRO's, were doing their jobs and that no major problems were developing.

As the agency with administrative and rulemaking responsibility for Medicare, HCFA is critical to the success or failure of the PRO program, the collection of data on quality and access under PPS and the overall operation of prospective reimbursement. But even in the light of increasing evidence of quality of care problems, HCFA repeatedly failed to acknowledge those problems or to take action to make the improvements needed in the statutes and regulations governing the PRO's.

(1) Effect of Prospective Payment on Quality

In February 1985, the Senate Special Committee on Aging launched an investigation into quality of care under PPS. Committee staff visited and collected data from five PRO's, and a number of community and university hospitals. The inquiry involved scores of interviews with Medicare beneficiaries, practicing physicians and nurses, university researchers, personnel from the Health Care Financing Administration, and the Department of Health and Human Services Office of Inspector General. In addition, committee staff gathered and analyzed volumes of records obtained from these organizations and individuals.

The committee's investigation led to three hearings in the fall of 1985: September 26, October 24, and November 12. The committee looked at quality of care issues in the hospital and post-hospital settings and heard witnesses from 14 States detail a large variety of problems with quality and access. The committee also heard from a wide-ranging set of experts on ways to respond to the various problems developing under PPS.

The committee found that quality of care problems were widespread, and that the PRO's felt hamstrung in their ability to perform their watchdog responsibilities. The most serious problems were at the point of discharge from the hospital. Too often, hospitals discharged patients without regard to the appropriateness of post-hospital care.

Specifically, the committee looked at the nature and extent of quality of care problems, their causes, and possible solutions.

(a) Earlier discharge

Patients were being discharged in a poorer state of health than before PPS. Case histories brought to the attention of the Senate Special Committee on Aging revealed that medically unstable patients had been prematurely discharged.

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[35] Carolyne Davis, Ph.D., Administrator, HCFA, Testimony, U.S. Congress, Senate Committee on Finance, Subcommittee on Health, Hearing on Peer Review Organizations. 99th Cong. 1st sess., April 19, 1985. Washington, DC, U.S. Government Printing Office, 1985, pp. 51-52.

(b) Denial of access

Some hospitals denied admission to patients with multiple serious conditions. Several physicians and hospital administrators described cases where patients deemed "DRG losers" were denied admission or inappropriately discharged from the hospital.

Experts testified that the DRG system does not account for differences in severity of illness. (Severity of illness refers to the fact that two patients with the same diagnosis may require different levels of care, particularly if one is older or there are other complicating conditions present.) As a result, equitable reimbursement—where hospitals are reimbursed adequately, but not excessively for patient care—cannot be assured under DRG's. This places the heavy care patient in jeopardy of falling victim to a hospital's fear of financial loss and being prematurely discharged, inappropriately transferred, or refused admission.

(c) Inadequate rights of appeal

Many patients who may have wanted to present evidence of substandard care or challenge a discharge decision were unaware of their right to appeal, were given false or incomplete information regarding their right to appeal, or lacked the necessary advocacy systems essential to appeal a discharge decision on their behalf.

Hospitals are required by law to "inform Medicare beneficiaries at the time of admission, in writing, that the care which Medicare payment is sought will be subject to PRO review and indicate the potential outcomes of that review"—i.e., that the PRO can deny reimbursement. This did not assure the beneficiary of any explanation on how to appeal to the PRO as the agent of Medicare. There was also no standard language for hospitals to inform patients about DRG's and PRO's or about their rights to appeal. Not only was the information on exercising one's right practically nonexistent, but those substantive rights themselves were deficient. The law contained too many loopholes through which hospitals can escape the responsibility of providing notice and appeal rights to beneficiaries.

(d) Pressures on physicians

Some hospitals were pressuring doctors to treat patients in ways that violated good medical judgment in order to save money. For example, a physician from a Pennsylvania hospital testified that his hospital had decided to warn doctors that their privileges could be jeopardized if their patients frequently overstayed the DRG average lengths of stay. A physician from North Carolina testified that one hospital in which he practices had begun to pressure physicians toward quicker discharges by publicly ranking and comparing those physicians with longer and more costly patient stays to those with shorter money-saving patient stays. Physicians' decisions to admit or not to admit patients for hospital care were often based upon inflexible sets of DRG "cookbook" admission criteria.

(e) Limited scope of PRO's

HCFA focused the PRO's on a very narrow and incomplete set of quality issues, and therefore HCFA's assessment of quality of care was grossly deficient. The PRO's first contractual scope of review was limited to cases where the patient was readmitted to a hospital within 7 days. Thus, cases of readmission after 7 days or to hospitals outside the PRO area, deaths after premature or inappropriate discharge, denials of admission, inappropriate placement out of the hospital and lack of adequate care in the community were not reviewed by a PRO.

Thomas Dehn, M.D., President of the American Medical Peer Review Association [AMPRA], testified that HCFA primarily wanted data from the PRO's on utilization—i.e., number of admissions, costs per admission, etc.—and was less concerned with quality review. AMPRA's report, "PROs: The Future Agenda," dated September 1985, and prepared by its Task Force on PRO Implementation, concluded that, "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of in-patient care to the elderly. Only now are quality of care concerns surfacing."

Prior to COBRA (Public Law 99-272) Federal law did not permit PRO's to deny payment to a hospital or physician on the basis of poor quality of care. When PRO's found a utilization problem (such as admission for a procedure that should have been done on an outpatient basis), they could unilaterally deny reimbursement under Medicare. However, when PRO's found a quality of care problem, no immediate action could be taken. Instead, they were required to refer it to the Secretary for an eventual decision on whether to seek repayment from the provider or exclude the provider from participation. Further, the PRO's were only required to report quality of care problems if there was a pattern of substandard care or one particularly egregious instance.

(f) Inadequate post-hospital care

Large numbers of Medicare patients who were discharged quicker and thus sicker often found post-hospital care unavailable or substandard. The stress on post-hospital services is increasing substantially. As GAO concluded from its survey of providers, "evidence of a trend toward increased use of home health services may not be showing up on early reports of the use of Medicare home health services that are based on hospitals' discharge data . . . A large proportion of monthly hospital referrals to home health care (in one hospital, 89 percent of all discharges were to home health) were not showing up as discharges to home health care on the hospital discharge abstracts processed by the peer review organizations."

GAO stated in its February, 1985 report that at each site they visited, "the view was expressed . . . that patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to PPS." Providers of post-hospital care confirmed to the committee that Medicare admissions to nursing homes had increased dramatically since DRG's began. These witnesses reported that, "PPS has resulted in more and sicker patients being released into the community, often to the care of families who are not prepared or able to adequately care for them . . . With the shorter length of stay and reduced staff in many hospitals, patients are often too sick to respond positively to educational efforts and nurses are too shorthanded to spend the extra time" required to train the patient and the family to provide the care that will be needed at home. In addition, existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS with the result that Medicare patients often received inadequate post-hospital care. Moreover, not all hospitals provide discharge planning, and many that do have inadequate programs.

Results of a committee investigation confirmed HCFA internal reports of nearly a 40-percent increase in discharges to skilled-nursing and home health care since October 1983. But home health and nursing home care in the community is often unavailable. Testimony at an earlier hearing of the committee showed this shortage is aggravated by widespread illegal discrimination against (Medicare and) Medicaid eligible patients. Nursing homes prefer to take patients who will pay higher private rates as well as patients whose conditions are less costly to care for.

Community services are even less available when one looks at the quality of facilities. For example, more than 970 nursing homes have been chronically substandard for years, according to HCFA data, but these facilities still retained their certification to receive Medicare and Medicaid patients.

Adding to the problem is the fact that HCFA has sought to reduce nursing home and home health care utilization through administrative denials of reimbursement. William Dombi, attorney from Legal Assistance for Medicare Patients, [LAMP] in Connecticut, testified on October 24, 1985, that HCFA has "circumvented the law and subverted the intent of Congress . . . through oral and written policy directives, all designed to curtail home health and skilled nursing facility coverage." Mr. Dombi went further to assert that "there are two Medicare programs, the one that is in the books under 42 USC section 1395 (and the one based upon the) directives of the Health Care Financing Administration." Other witnesses from the long-term care provider community confirmed that "patients cannot be admitted for care because of restrictive HCFA guidelines."

(g) Inadequate data

According to the GAO, which testified at the November 12 hearing, DHHS lacked any statistically valid basis to confirm or deny the effect of DRG's on the quality of health care older Americans need or receive upon discharge from the hospital. GAO stated that DHHS did not have the necessary data to evaluate whether PPS had either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Furthermore, DHHS was not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

There were, however, significant indications that these problems were more severe and widespread than HCFA's estimates. According to HCFA's own reports, between October 1, 1983, and May 31, 1985, 4,724 cases of suspected inappropriate discharges and transfers had been reported by the PRO's.

(h) The evidence 1 year later

In the year since the Aging Committee's third hearing on quality of care under PPS, its findings have been reinforced by new studies and government investigations. In April 1986, the Office of the Inspector General [OIG] of the Department of Health and Human Services reported that it had found substantial evidence of premature discharges and inappropriate transfers from our Nation's hospitals. The OIG also found that the PRO's had not been effectively using their enforcement powers to address instances of poor quality care. During the period reviewed, October 1, 1983, through May 5, 1985, 14 of the PRO's studied were not reporting premature discharges and inappropriate transfers. The IG concluded that, "therefore, the overall extent of the problem is still not fully known." Quality issues ranged from minor to gross and flagrant violations. Further, the IG placed blame for this problem on the doorstep of HCFA for failing to give clear and consistent guidance to the PRO's as to their quality assurance responsibilities.[36] While HCFA issued clarifying instructions to the PRO's in July 1985, the OIG had received only 30 proposed sanctions from 9 PRO's through May 1986.[37]

In June 1986, the General Accounting Office [GAO] released its final report regarding the adequacy of DHHS's efforts to evaluate the effects of PPS on post-hospital services. In the report, GAO again criticized the Department's failure to implement an appropriate evaluation plan for determining the effects of PPS on post-hospital services, and made a number of recommendations on how the Department could improve on those efforts.[38]

On September 15, 1986, GAO released its findings from its survey of the California, Florida, and Georgia PRO's in respect to their quality of care activities. GAO outlined two major conclusions: First, although PRO's were required to collect data on substandard care provided to beneficiaries during the first contract period, these three PRO's did not compile and analyze the data to identify providers with recurring quality problems that might have warranted further review. (The PRO's understood that this would be expected of them for the second round of contracts but chose not to do it for the first contract period.) This was true even though the Florida and Georgia PRO's had identified a number of providers with recurring quality problems. "Profiling the earlier data (1984-86) would enable PRO's to use this quality monitoring technique sooner than if they used only data under the new contracts." [39] Second, the GAO concluded that PRO's should monitor inappropriate discharges of beneficiaries needing skilled nursing care. "Because PPS creates incentives for hospitals to discharge patients as quickly as possible, we believe HCFA should require PRO's to monitor hospitals to assure that Medicare patients are allowed to remain in the hospital when their conditions warrant placement in a skilled nursing facility but no bed is available." [40]

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[36] U.S. Department of Health and Human Services, Office of the Inspector General, Inspection of Inappropriate Discharges and Transfers. April 1986.

[37] Richard Kusserow, Inspector General, Department of Health and Human Services, Testimony, U.S. Congress, Senate Committee on Finance, Subcommittee on Health. Hearing on the Quality of Care under Medicare's Prospective Payment System. June 3, 1986.

[38] General Accounting Office, Report to the Chairman, Special Committee on Aging, U.S. Senate, "Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects are Insufficient," June 1986, PEMD-86-10.

In December 1986, the American Medical Association released a new random survey of 1,000 of its members on issues related to quality of care. Forty-eight percent of the physicians surveyed said they felt "unduly pressured" to discharge Medicare patients early, while 28 percent felt no pressure. The remainder were unsure or did not answer.

While it is disconcerting to see repeated indications of quality breakdowns in the Medicare system, it is encouraging that more and more attention is being directed to quality of care issues by researchers, the Congress, and the Department of Health and Human Services. In the next few years, it is certain that the health policy agenda will be dominated by the need to reconcile cost containment with the adverse effects on quality that such squeezes on the system will produce.

(2) Unfit Health Practitioners

Another concern relating to the quality of health care has been the effectiveness of Federal and State authority in regulating unfit health practitioners. As part of its ongoing efforts to safeguard the quality of care provided to Medicare and Medicaid recipients, the U.S. Special Committee on Aging held a hearing in May 1984 to highlight serious defects in the ability of the Federal Government to protect the elderly and others from treatment by incompetent and dangerous medical practitioners. The problem stems from the limited authority possessed by the Secretary of the Department of Health and Human Services to exclude practitioners from participation in, and reimbursement from, the Medicare and Medicaid Programs.

Licensing of health care professionals is a responsibility of the States, and practitioners can, and often do, hold licenses in more than one State. State licensing boards are empowered to sanction practitioners for their improper actions related to any patient, and when the board suspends or revokes a practitioner's license, he or she can no longer legally provide services in that State.

In sharp contrast to this broad State power, DHHS has very limited authority to sanction practitioners. The Secretary is responsible only for practitioners' participation in Medicare and Medicaid, not for their other services, and can sanction practitioners or exclude them from Medicare and Medicaid only for specific acts committed against those two programs and their beneficiaries.

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[39] U.S. General Accounting Office, Report to the Administrator, Health Care Financing Administration, "Medicare: Reviews of Quality of Care at Participating Hospitals," Washington, DC, GAO/HRD-86-139, p. 2.

[40] *Ibid.*

Because DHHS has limited exclusion authority, practitioners who are found by the Secretary to be unfit to participate in Medicare or Medicaid in a particular State, or are found by a State licensing board to be unfit to practice in that State, pose a threat to all Medicare and Medicaid patients. This is because they are able to relocate to another State in which they are licensed and set up another practice with no assurance that the problems which led to their sanctioning in the first State were corrected before they began treating Medicare and Medicaid patients in the other State. This situation was confirmed by a General Accounting Office [GAO] investigation which revealed that Medicare and Medicaid patients are being treated in some States by doctors and pharmacists who have been stripped of their licenses to practice in other States for reasons which do not justify national exclusion from Medicare and Medicaid under the Secretary's current exclusion authority. The GAO also identified a number of specific problem areas and gaps in the Secretary's exclusion authority, including the inability to ban from both programs a doctor found guilty of fraudulent practices in one (see Legislation).

(C) REIMBURSEMENT PROBLEMS UNDER PROSPECTIVE PAYMENT [PPS]

1986 was the third full year for Medicare under prospective payment and the system was still experiencing many wrinkles. As the effects of PPS were being more fully realized by hospitals, pressures increased for various adjustments to the DRG's as well as for delays or changes to the schedule for the phase-in to national payment rates. In addition, physician reimbursement, capital payment reform, and the status of rural hospitals emerged as major issues requiring further action over the next few years. Congress also grappled with health care providers' concerns about delays in Medicare reimbursement and the implementation of the disproportionate share adjustment enacted in COBRA (Public Law 99-272).

Because payment adjustments under PPS are generally made within a budget-neutral framework, most of the above are allocation rather than budget issues. Any adjustment will produce winners; it will also produce losers. Consequently, much of the debate over PPS changes tended to divide the hospital industry along regional and geographic lines. There were also major tensions between teaching and nonteaching facilities. Many of the issues were interrelated: The transition to national rates, adjustments in payments for rural facilities, and reimbrusement for medical education all have a direct bearing on each hospital's Medicare payment. Congress addressed each of these issues in the context of deficit reduction and through the House and Senate budget reconciliation process. The Senate Finance Committee also used a health care fraud and abuse bill (H.R. 1868) as a vehicle for Medicare changes in 1986, but ultimately, all the changes in Medicare law were enacted through the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).

(1) Hospital Payment Issues

(a) Transition to national rates and increasing the DRG payments

Under Public Law 99-272, the transition from hospital specific costs to a fully phased-in national DRG payment rate was delayed for 1 year for all but Oregon, postponing full implementation from October 1, 1986, to October 1, 1987. The original transition period was intended to provide time for finetuning of the prospective payment methodology. Hospitals that stand to lose money from the transition to national rates have worked continuously to freeze or slow the transition, a position that has been unpopular with the rest of the hospital community and with the administration.

In 1986, the hospital industry focused far more on the adequacy of the increase in the PPS payment than on the schedule of the transition to national rates. Rural hospitals in certain regions also pushed for a change in the way in which the payment rates are computed so that more dollars would flow to them.

Under the administration's fiscal year 1987 budget, hospitals would have received only a 0.5-percent increase in their PPS payments, well below the marketbasket increase that was scheduled under COBRA (Public Law 99-272). The administration did not propose any changes in the basic calculation of the PPS payment rate.

The debate over the PPS payment rate struck at the heart of the question of whether hospitals were coming out losers or winners under the new system. The administration, using data complied by the DHHS Office of the Inspector General, argued that hospital profits were at record levels and that the 0.5-percent increase was higher than justified by their analysis of health care costs. The study did indicate, however, that small rural hospitals were not faring quite so well. The hospital industry countered that PPS had forced them to reduce staffs and economize to the point where no further reductions were possible without jeopardizing quality and access to care. They had just experienced a 0.5-percent reduction in their fiscal year 1986 payments as a result of the Gramm-Rudman-Hollings sequester, and did not believe that it was fair to seek further budget savings at the expense of the hospital industry. Moreover, in July 1986, the Prospective Payment Assessment Commission [ProPAC] recommended a 2.2-percent increase in the fiscal year 1987 rates if capital was to be included in the prospective payment system or a 1.9-percent increase without capital.

(b) Area wage index

The area wage index is an important element used in the calculation of the regional and national standardized DRG payments to hospitals. This was done to ensure that the DRG payments reflect differences in wages from area to area. To compute the initial wage index, HCFA used hospital wage and employment data maintained by the Bureau of Labor Statistics [BLS] of the Department of Labor. However, it is generally recognized that this data base does not accurately reflect differences among hospitals. The principal limitation of the BLS data—their inability to recognize local differences in the number of part-time hospital workers—was cited by a large number of hospitals, particularly rural midwestern facilities.[41] Under the Deficit Reduction Act of 1984 (Public Law 98-369), HCFA was required to report to Congress on a refined wage index which was to be implemented retroactive to October 1983. In 1984, HCFA attempted to obtain better data on wage differences through a survey of hospitals, but the survey was hampered by a low response rate and questionable data quality.

The required report,[42] which was released to Congress in March 1985, proposed two alternatives. One wage index was derived from total gross hospital wages, which included salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers and hospital-based physicians. The other index excluded several variables from its calulation and was referred to as the adjusted gross index. On September 3, 1985, HCFA implemented a new wage index for discharges occurring on or after October 1, 1985. This index was based on the gross wage data from HCFA's 1984 survey. The rule also provided that the retroactivity required by current law would not come into effect until April 1, 1986. This was done to allow time for Congress to reverse the retroactive provision and for HCFA to develop a method to identify retroactive amounts.

There remains today a number of hospitals which are challenging their classification as rural facilities on the grounds that their proximity to urban areas results in urban usage and salary demands and the other higher costs associated with being located in urban areas. HCFA has been unwilling to reclassify these facilities. ProPAC has also encouraged DHHS to improve the hospital labor market areas. HCFA has responded by saying that further research is necessary before alternative labor market definitions are specified.

The Secretary is required to report to Congress on a method of improving urban labor market definitions by May 1, 1987. Congress did not include any provisions in OBRA (Public Law 99-509) affecting the area wage index, although it did make changes in the calculation of the urban and rural standardized amounts that are factored into the DRG payment. This change will benefit many rural hospitals (see Legislation).

(c) Graduate medical education

Since its beginning in 1965, Medicare has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include salaries and fringe benefits for residents, faculty, and support staff; the cost of conference and classroom space in the hospital; any costs of additional equipment and supplies; and allocated overhead costs. Physician graduate medical education is the most costly component of health professions education paid under Medicare.[43] In fiscal year 1986, Medicare's payments to hospitals for the direct costs of graduate medical education were about $1.3 billion.

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[41] Department of Health and Human Services, Health Care Financing Administration, Report to Congress on the Hospital Wage Index as required by section 2316(a) of Public Law 98-369, Washington, DC, March 28, 1985.

[42] *Ibid.*

[43] U.S. Library of Congress, Congressional Research Service, Background Paper for use of the Members of the Senate Finance Committee on Payments for Medical Education by the Medicare Program. Washington, DC, May 1985.

Medicare also pays teaching hospitals an additional amount, called the indirect adjustment, to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in nonteaching hospitals. Medicare's payments for indirect teaching costs were expected to be $1.4 billion in fiscal year 1986. In total, Medicare spent an estimated $2.7 billion on medical education in fiscal year 1986. Medicare is the single largest payer for health professions education in hospitals.[44]

When the Medicare Program was established, Congress was clear in its intent that Medicare should support the clinical training of health personnel. As a result of Medicare payment policies and additional Federal support of the health professions through NIH and title VII of the Public Health Service Act, a vast network of medical and health profession schools developed throughout the country.

This growth in medical education has helped ease what was once a substantial physician shortage to the point where many now argue that we are in danger of having too many physicians by the end of the decade. According to a report by the Graduate Medical Education National Advisory Committee [GMENAC] published in 1980, there will be 70,000 excess physicians by 1990 and 145,000 excess physicians by 2000. A 1984 study by DHHS has predicted an excess of more than 35,000 physicians by 1990 and about 51,000 by 2000. However, while in the aggregate there may be too many physicians, a physician shortage will exist for certain specialty areas such as psychiatry and primary care specialists.

There is also evidence that there remain a large number of medically underserved areas in the Nation, indicating that excess supply does not directly alleviate maldistribution problems, especially in poor inner-city neighborhoods and remote rural areas. The DHHS and GMENAC reports also reinforce growing concerns about the appropriateness of continued Medicare funding for foreign medical graduates [FMG's]. On the one hand, FMG's have helped alleviate shortages in some geographical areas; on the other hand, they are viewed as feeding the physician glut.

With mounting pressures on the Medicare hospital insurance trust fund, the growing Federal deficit, and the increased supply of physicians, the administration and many in Congress have begun to question whether Medicare's payments for graduate medical education should be continued. Direct payments for medical education are especially problematic because they are still paid on a pass-through or open ended basis, that is, the incurred costs of approved programs are reimbursed regardless of the nature and costs of the program.

Nevertheless, indirect payments are also a target for cuts because they are seen as too generous. The indirect adjustment serves as a proxy for other factors that are not adequately recognized by DRG's but that may increase costs in teaching hospitals which traditionally treat sicker patients. These include higher case severity, greater intensity of service, and in some cases, disproportionately large amounts of uncompensated care. In 1983, with the implementation of DRG's, Congress decided to apply a doubled indirect medical education adjustment to the DRG's to substitute for those factors noted above. HCFA claims that the indirect adjustment is unjustified, saying that there is no empirical evidence to support the doubling of the adjustment. HCFA concludes that it therefore makes sense to return the adjustment to its original (5.95) level.

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[44] *Ibid.*

In response to these and other concerns, various proposals have been offered to change the way in which Medicare pays hospitals for health professions education. In the administration's fiscal year 1986 budget, a freeze on direct graduate medical education payments was proposed. In addition, the administration called for a 50-percent reduction in indirect payments. Together, these measures would have produced a 31-percent reduction in Medicare support for graduate medical education. They drew instant criticism from the American Association of Medical Colleges [AAMC] and its member institutions which recommended against the freeze. In its place, AAMC urged that Congress amend DRG's to reflect heavier hospital-specific weighting in the payment formula. This set the stage for a heated debate in Congress over the future of Medicare's support for graduate medical education, and in COBRA (Public Law 99-272), Congress did make a number of changes in Medicare's reimbursement for medical education. Under the new law, Medicare payment limits for direct support are established on each hospital's average cost per resident and on the number of years of training provided to residents. COBRA also reduced the indirect medical education adjustment factor to approximately 8.1 percent from May 1, 1986, to October 1, 1988 applied on a curvilinear basis, meaning the payment would not necessarily increase in direct proportion to the ratio of interns and residents to bed size. In tandem with this cut, Congress provided for a temporary adjustment for hospitals with large percentages of low-income Medicare and Medicaid patients. When the adjustment ends on October 1, 1988, the indirect payment will be approximately 8.7 percent.

Despite these changes, the administration has continued to seek reductions in Medicare payments for graduate medical education. In its fiscal year 1987 budget and in proposed regulations, the administration sought to (1) eliminate payments for the education expenses of interns and residents while continuing to pay for their salaries; (2) establish hospital-specific limits on payments for intern and resident salaries; and (3) eliminate payments to hospitals for nurses and allied health training. The administration also proposed again to reduce the indirect adjustment to the 5.8 level (see Legislation).

(d) Medicare and uncompensated care

Traditionally, the public-private patchwork of health insurance coverage has afforded basic protection to a majority of Americans. However, today there are 35 to 37 million Americans who find themselves without health insurance. Approximately 17.1 percent of the population under age 65 is uninsured. Of these, 5.5 million are age 45 to 54 and 2.9 million are age 55 to 64. Surprisingly, 389,000 persons over the age of 65 are without insurance of any kind even though the common perception is that the elderly are taken care of by Medicare and Medicaid.[45]

The number and proportion of the uninsured is increasing substantially. The number of uninsured nonaged persons increased by 20.4 percent from 1979 to 1983.

Prior to the last recession, the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time or low-skilled jobs, in which employers generally did not provide health insurance coverage. Most working Americans received health insurance through their or their spouse's employer. Others were protected by public insurance programs or their costs were picked up by health care providers who subsidized nonpaying patients by shifting these "bad debts" and "uncompensated care" patients to other payers.

But during the last recession, 10.7 million Americans lost their admission tickets to the health care delivery system. These people lost health insurance protection when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Cutbacks in Medicaid and other public programs have caused cracks in those sources of health care which directly serve America's uninsured. In addition, the changing nature of America's health care, with reforms in reimbursement, heightened competition and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured to obtain even emergency access to health care.

Before prospective payment, many hospitals were able to shift the burden of providing high levels of uncompensated care to Medicare and other payers, such as Blue Cross. Under PPS and the threatened ratcheting down of Federal payments, as well as tightening reimbursement policies among private payers, hospitals are increasingly reluctant to take patients for whom there is no guarantee of reimbursement. The shrinking number of hospitals that do take large numbers of low-income patients argue that such patients are generally sicker and require greater intensity of services. To the extent that these hospitals are bearing a disproportionate burden of such patients, they assert that they should be receiving a reimbursement which reflects this special burden.

Disproportionate share hospitals.—Legislation addressing disproportionate share hospitals [DSH's] was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) which established the foundation for Medicare's PPS. The Secretary of DHHS was required to provide for exemptions from, and adjustments to, the cost limits then in effect for Medicare reimbursement to hospitals. HCFA did not implement the provision because, as was indicated in regulations, it did not have the data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. A similar provision for DSH's was included in Public Law 98-21, the measure creating Medicare's PPS. Under this act, the Secretary was charged with developing a methodology for a DSH adjustment to the DRG's. Again, HCFA indicated in regulations that it would not implement the provision in fiscal year 1984 or fiscal year 1985 because it did not believe that it had the evidence to justify the adjustment. In Public Law 98-369 (the Deficit Reduction Act of 1984), Congress required the Secretary to develop a definition of disproportionate share hospitals and to identify such hospitals by December 31, 1984, which it failed to do.

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[45] U.S. Congress, Senate Special Committee on Aging, "Americans at Risk: The Case of the Medically Uninsured." Background paper prepared by the Staff. Washington, DC, June 27, 1985.

The special needs of DSH's have been the subject of much debate and have greatly influenced congressional action on a number of issues related to Medicare hospital reimbursement. Special needs could be interpreted to include a broad array of specific problems found in hospitals serving low-income or Medicare patients, ranging from potentially higher costs of treating patients that are more severely ill to the cost of providing uncompensated care. Generally, they have been interpreted more narrowly. Thus, the costs of additional services and more costly services that may be required to meet the needs of low-income or Medicare patients, would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, the possibility of additional payments to hospitals under Medicare for such costs as uncompensated care have been excluded, usually on the grounds that section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the costs of services provided to persons not entitled to benefits under the program.[46]

On April 1, 1985, the Prospective Payment Assessment Commission, which was mandated by Public Law 98-21 to advise the Secretary and Congress on PPS issues, recommended that a DSH provision be included in fiscal year 1986 PPS rates.[47] Armed with this recommendation, and frustrated by HCFA's inaction, the Ways and Means Committee decided to come up with its own adjustment, and included a provision in its deficit reduction package. In response to a court order from the U.S. District Court for the Northern District of California, resulting from the lawsuit of a small California rural hospital, HCFA published proposed rules implementing the DSH provision on July 1, 1985 (*Redbud Hospital District* v. *Heckler*). However, HCFA made clear that it would award such an adjustment only in extraordinary cases and only after a case-by-case review. HCFA also appealed the decision.

In the meantime, the Senate Finance Committee also provided for a DSH adjustment in its deficit reduction bill. Conference action on the bill, enacted as COBRA (Public Law 99-272), resulted in the following: The disproportionate share adjustment is applied to the Federal portion of the DRG rate for hospitals with a relatively high percentage of low-income patients. Urban hospitals with at least 100 beds receive a graduated adjustment from 2.5 to 15 percent, if their disproportionate patient percentage is at least 15 percent. Smaller urban hospitals receive an adjustment of 5 percent, if their disproportionate patient percentage is at least 40 percent. Rural hospitals receive an adjustment of 4 percent, if their disproportionate patient percentage is at least 45 percent. The adjustment applies to all discharges after April 30, 1986, and before October 1, 1988. (OBRA, Public Law 99-509, extended the adjustment to include all discharges before October 1, 1989.)

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[46] U.S. Library of Congress, Congressional Research Service. Medicare Payment Provisions for Disproportionate Share Hospitals. Background Paper. Prepared for the use of the Members of the Committee on Finance, Washington, D.C., July 1985.

[47] U.S. Dept. of Health and Human Services, Prospective Payment Assessment Commission, Report and Recommendations to the Secretary. Washingtron, D.C., April 1, 1985.

(e) Capital reform

1986 was supposed to be the year in which Congress completed work on a comprehensive plan for reforming the way in which Medicare pays for hospitals' capital-related expenditures. The year ended, however, without the completion of such a reform, although the Congress and the hospital industry moved closer to a consensus on how to handle some of the more thorny issues related to the placement of capital under the prospective payment system.

Under current law, hospitals are reimbursed on a retrospective cost basis for their expenditures for equipment and facilities, including depreciation costs, and return on equity. The passthrough of capital costs has encouraged hospitals to make capital investments, whether or not those investments are justified in terms of the needs of their communities. Moreover, as ProPAC has noted, the passthrough encourages early retirement of assets, promotes insensitivity to interest rates and financing methods, and favors capital over labor resources. In 1984, Medicare paid about $3.2 billion for capital-related costs.

In establishing the prospective payment system with the enactment of the Social Security Act Amendments of 1983 (Public Law 99-21), Congress deferred action on incorporating capital-related costs until October 1, 1986. This delay reflected a recognition that further study was necessary before these costs could be incorporated under PPS. Under Public Law 98-21, however, Congress also provided that if capital was not brought under PPS by October 1, 1986, all States would have to review hospital capital expenses under the Section 1122 program. (This date was later moved back to October 1, 1987, with the enactment of Public Law 99-349, the Urgent Supplemental Appropriations Act.)

The administration was supposed to deliver a report to Congress on capital payment options by October 1, 1984. It was finally delivered to the Congress in March 1986, although much of its content had been revealed earlier. The report, "Hospital Capital Expenses: A Medicare Payment Strategy for the Future," outlines trends in hospital capital investment, discusses practices and problems with Medicare reimbursement for capital as well as other Federal policies affecting capital payments, and sets forth a number of options and recommendations for capital payment reform.

The administration also communicated its recommendations for capital reform through the fiscal year 1987 budget proposal. It proposed by regulation to include capital costs in the prospective payment system rates for inpatient hospital services beginning in fiscal year 1987. After a 4-year transition that would end in 1990, a fixed payment that includes both capital and operating costs would be made for each Medicare discharge. During the 4-year phase-in period, a declining portion of a hospital's payment for capital costs would be based on a hospital's capital costs and an increasing portion would be based on a national rate per discharge. Hospital data from 1983 cost reports would be used as a base for calculating the national urban and rural capital-related base amount. Payments each year would be based on the lower of the hospital's allowable actual capital costs or the base year amount trended forward by the capital marketbasket. The national payment amounts would be updated from 1983 to fiscal year 1986 by the appropriate capital marketbasket indexes. The administration estimated that the plan would save $390 million in fiscal year 1987 and $3.6 billion over 3 years.

The hospital industry universally condemned this proposal as unreasonable and inequitable, arguing that it would lead to severe hardships for hospitals with substantial capital expenditures. The industry also objected to the use of 1983 data as the base for calculating the national urban and rural base amounts, because they provided an unrealistic measure of current hospital expenditures on capital investments.

In the months following the submission of the President's budget, the hospital industry lobbied hard for an alternative capital proposal that included a 10-year transition to national rates and the use of more recent data in determining the capital add-on to the DRG's. Later in the year, the industry united around a plan to grandfather under cost-based reimbursement all capital costs incurred before a certain date (e.g., December 31, 1985) and would provide for a phase-in of new capital expenditures under PPS over 10 years.

Key congressional health leaders rejected the administration's proposal outright and began to seek alternatives that would be more equitable to the hospitals and yet would help contribute to deficit reduction. Senator Durenberger and Representatives Stark and Gradison led the way to find acceptable capital reform plans that would be fair to the hospitals but which would also encourage more appropriate investment behavior. ProPAC also developed a proposal in which it recommended that costs for moveable equipment be immediately included as a fixed percentage add-on to the standardized DRG payment, but that prospective payments for building and fixed equipment be phased in over a 7- to 10-year period as a fixed percentage add-on to the standardized amount. ProPAC argued that separate treatment of moveable and fixed capital is justified because of their different characteristics. The debate over these alternatives was carried into the annual reconciliation process, where each of the plans ran into opposition from various members of Congress and the hospital industry, and a final resolution was postponed until next year.

(f) Rural health care

The effects of cost containment are being experienced by the hospital industry at large. Rural hospitals, however, are perceived by many experts to have a special set of problems that make them more vulnerable to the changes that have come along either as a result of or in tandem with PPS: fewer hospital admissions, declining lengths of stay; and increasing severity of illness of the patients who are admitted to hospitals.

Rural hospitals may be hit more severely by these changes because their costs are spread over a smaller number of patients, or because they have a number of other characteristics that "set them apart from hospitals in nonrural areas. They are smaller, have fewer personnel and specialized services, lower occupancy rates, and serve a population more likely to be underinsured as well as older than average. Rural hospitals are more likely to be owned by local governments and are generally less costly to operate than urban hospitals. The rural hospital also is more likely to be the focal point for the health care provided within a large geographic community."[48]

In 1986, congressional concern about the status of rural hospitals was fueled by growing reports of hospital bankruptcies and closures in rural areas. Of the 49 community hospital closings in 1985, 21 occurred in rural areas and 28 occurred in urban areas. Three rural specialty hospitals closed and 9 urban specialty hospitals closed.[49]

There is considerable debate among health policy experts whether steps should be taken by the Federal Government to prevent the closing of rural hospitals, especially those which are the sole providers in their area. While such hospitals may not be economically efficient, they often play a role in the community that goes beyond the provision of inpatient hospital services. They are often the single largest employer in the area and they help to attract primary care physicians who want to be assured that they are in reach of specialized technology and staff. And in some areas of the United States, the small rural hospital provides the only health care in the area. In its absence, people would be forced to travel hundreds of miles to obtain medical care.

Some rural hospitals are attempting to diversify their services to generate new revenues. A popular strategy is to convert a number of beds to postacute beds and to offer home care and social services. Other hospitals are entering into multihospital arrangements to help ease their financial strains. These arrangements can include affiliations, shared services, consortium, contract management, leases, corporate ownership with separate management, and complete ownership. The advantages of joining such arrangements include cost savings from joint purchasing and shared services; certain operating advantages such as increased productivity and lower staffing requirements; and improved access to capital resulting in lower interest costs.[50]

There are a number of features of the prospective payment system which have been identified as having an effect on rural hospitals, including the urban/rural DRG payment differential, the wage index adjustment, payments for outlier cases, and the special provisions for sole community providers, referral centers, and hospitals serving a disproportionate share of poor patients. Congress has acted as a court of appeals on many of these issues because DHHS has been slow to complete mandated studies and has also resisted granting exceptions or adjustments that would reverse the transition to standardized national DRG payments.

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[48] Rural Hospitals and Medicare's Prospective Payment System, Background Paper, Prepared for the use of the Members of the Committee on Finance, May 1986.

[49] *Ibid.*, p. 14.

[50] *Ibid.*

(g) Prompt payment/Periodic Interim Payment [PIP]

Medicare benefits and those who provide services to beneficiaries are reimbursed through fiscal intermediaries and carriers. These are entities—usually insurance companies such as Blue Cross and Blue Shield—that contract with Medicare to handle claims processing, auditing, payment safeguards and other such responsibilities. Congress approves an annual budget for HCFA to administer the Medicare Program which includes within it funds for the carriers and fiscal intermediaries. In recent years, the administrative budget has been tightly controlled as part of efforts to hold down Medicare expenditures; it took another blow when the sequester required by Gramm-Rudman-Hollings resulted in a 4.3-percent reduction in its fiscal year 1986 appropriation.

Under these budget reductions, Medicare contractors have reduced service levels to providers and beneficiaries, claiming that they are receiving inadequate payment to perform the increasing volume and scope of work. Consequently, it is taking more time to process claims and to respond to inquiries. Efforts to control benefit payments have also decreased, resulting in lost dollars for the Medicare trust funds.

In early 1986, DHHS issued a policy directive to all Medicare contractors to slow down the time in which claims are processed to at least 30 days. The administration projected that turnaround time would increase from an average of 23 days to 34 days. The administration justified the slowdown as a way to save money for the Medicare Program. Delayed payment would allow the Government to collect $130 million in annual interest on the Medicare trust funds.

This decision was opposed by Medicare contractors, provider and beneficiary groups. The contractors argued that HCFA was setting an arbitrary turnaround time which would result in an enormous backlog in their claims processing. The providers said that the policy would result in even more extended delays in obtaining reimbursement than they were already experiencing and would produce serious cash flow problems. Moreover, providers were also facing the elimination of their periodic interim payments. Beneficiaries objected to the policy on similar grounds, but also argued that the policy would discourage physicians and other providers from taking assignment. Concerns were also raised by Members of Congress, some of whom introduced legislation to require that Medicare conform to prompt payment.

The administration had also proposed as part of its fiscal year 1987 budget the elimination of periodic interim payments [PIP] for all Medicare providers. Existing law did not specifically provide for PIP; however, regulations allow hospitals, skilled nursing facilities and home health agencies which meet certain requirements to receive Medicare PIP every 2 weeks, based on estimated annual costs without regard to the submission of individual bills. At the end of the year, a settlement is made.

As a result of the pervasive opposition to the HCFA instruction on delaying the payment of claims, DHHS reversed its policy and issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. Clean claims are those not requiring development for payment safeguard activities or additional information. The guidelines applied to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers. However, in August, DHHS went forward with a modification of its PIP proposal and issued final regulations eliminating PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987. This action was later modified by Congress (see Legislation).

(2) Physician Payment

Medicare's expenditures for physician services increased at an annual rate of 20.6 percent over fiscal years 1979–83. While reduced inflation and the fee freeze have curbed the rate of increases, physician payments are still on the rise, fueling the desire of the administration and Congress to reform the payment system.

Since 1983, the principal strategy for holding down expenditures has been the physician fee freeze and the participating physician program, neither of which were intended as long-term reforms. However, serious consideration of more fundamental changes has been hampered by a number of factors. These include major gaps in the data on what the program is currently paying for, opposition by physician groups to a major alteration in the fee-for-service/voluntary assignment approach, and the uncertainty concerning the actual impact of the major reform options on both the program and beneficiaries. With the increasing need to curb costs and the vast innovation and change occurring in the organization of physician practice, pressures for comprehensive reform are nevertheless likely to mount.

The major alternatives which are being discussed include fee schedules, paying for physicians' services on the basis of DRG's, or paying for services on a capitation basis. Studies of a number of options are currently being conducted by HCFA and other public and private entities. In February 1986, the Office of Technology Assessment released its major study on physician payment options,[51] which helped to form the debate as Congress continued to review possibilities for comprehensive reform. The following options are among those which are being considered.

(a) Physician payment options

Fee schedules.—The current de facto fee schedules based on local prevailing charge patterns would be replaced by a uniform fee schedule for all physicians' services. One way to do this would be to use a relative value scale [RVS], which is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index or weight and other services are assigned higher or lower numbers to indicate their value relative to that service. The use of RVS could make the payment system more sensitive to a physicians' time, skill, overhead costs and the complexity of the service. An RVS is not a fee schedule. However, it is translated into a fee schedule by use of a predetermined conversion factor. The drawback to RVS is that its complexity is such that a workable system may be difficult to develop.

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[51] U.S. Congress, Office of Technology Assessment, Payment for Physician Services: Strategies for Medicare, Washington, D.C., U.S. Government Printing Office, Februray 1986.

Fee schedules would rationalize the current payment system and place limits on payments for individual services. The key issue is the payment unit. It needs to be designed so that physicians are unable to manipulate the system by increasing or unbundling services or upcoding (coding for a procedure that is reimbursed higher than one actually delivered).

Physician DRG's.—Under the Social Security Act Amendments of 1983, DHHS was required to report to Congress by July 1985 on the feasibility of paying for physicians' services provided to hospital inpatients on the basis of DRG's. DHHS has not yet given Congress the report.

It is expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined rate for each of the 471 DRG's under the PPS system. The major advantage of this scheme is that it would establish a specified payment amount for all services provided during an inpatient stay. There are, however, numerous questions about the practicality and appropriateness of a DRG scheme for physicians. The existing DRG system is based on resource use in hospitals; it may not be an accurate measure of physicians' input costs. Another issue is who is going to receive the payment—the hospital, the attending physician or the medical staff? One consideration in making this determination is the degree of financial risk imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients requiring more intensive care than the average for a particular DRG. Placing an individual physician at risk could potentially encourage the provision of less care than was medically appropriate or the avoidance of more severe cases.

Another issue is the potentially dangerous alinement between hospitals and physicians under a DRG payment scheme. Under the existing system, the physician is the last remaining check on quality. If he or she is given the same incentives as the hospital to reduce care, then quality may deteriorate. Other issues involve potential gaming—multiple admissions to maximize reimbursement, shifting care to the outpatient setting, and similar manipulations of the system.

Capitation.—Medicare would contract with an entity such as a carrier, which would serve as an at-risk insurer in a defined geographical area. Medicare would essentially purchase a specified package of services for a specified per person price. The entity would be responsible for determining payment amounts and payment units. To assure beneficiary access to care at predictable levels of out-of-pocket costs, an entity could be required to obtain physician participation agreements from a certain percentage of physicians in the geographic area. The Federal Government would be required to determine the per capita (per person) payment amount. The system could be designed to be mandatory for all beneficiaries or optional.

Administration's voucher plan.—The administration has sought a combination of vouchers and capitation; it has backed off from DRG-based payments and uniform fee schedules based on relative value scales. Under the proposal, called the Medicare Voucher Act of 1985, the Government would make single payments (e.g., 95 percent of the per capita payment for Medicare—estimated to be around $200 per month) to an entity (health benefit organization), such as a private insurance company, to cover all physician services both in and out of the hospital. The idea is based on the HMO model. The theory is that if every Medicare patient is given the option of joining such a plan, doctors' groups, HMO's, and insurance and medical groups would compete to offer the best plans at the lowest costs, holding prices down while providing the required range of services. The insurers could keep the difference if the beneficiary's health care costs were less than the Federal payment. The insurers would have to absorb any costs above the payment. There would be an open season once a year for beneficiaries to elect plans and they would not have to pay more than they do now for copayments and deductibles.

There are many questions about the effects of such a proposal and it is likely to be heavily scrutinized by Congress and organizations representing the elderly. Initial concerns include whether beneficiaries will have the information and knowledge to make rational selections among the various plans. There is also a question of skimming and adverse risk. The healthier beneficiaries may opt for the capitated scheme leaving the basic Medicare Program to absorb the high cost, heavy care patients. Finally, there is a concern that the administration will be driven by budget concerns to hold the capitation payments low and to pare down the required benefit package.

(b) Inherent reasonableness

Payment for physicians' services is determined on the basis of customary, prevailing, and reasonable [CPR] charges. Under this system, charges for new procedures are initially priced high because of the new technologies involved. Once a procedure has become established and frequently used, these initial payment levels may be artificially maintained under the CPR system despite technological or productivity advances. For example, improved medical technology resulting in lower costs, or reduction in the time required to perform certain procedures due to increased medical proficiency, should result in lower charges. In the past, this has not generally occurred.

Medicare carriers have the authority to use factors other than CPR in determining whether a charge for a specific service is inherently reasonable. In addition, under COBRA (Public Law 99-272), the Secretary of DHHS is required to promulgate regulations specifying explicitly the criteria of "inherent reasonableness" that are to be used for determining Medicare payments. In 1986, DHHS focused through regulation on cataract procedures and payments for anesthesiologists who stand by and monitor the general care of a patient during a surgical procedure when the surgeon administers the local anesthesia. It is expected that in future years, the Department will focus on such procedures as pacemaker implants and cardiac bypasses. The medical community—especially the opthalmologists—objected strongly to DHHS's proposed payment changes for cataract reimbursement; Congress responded with competing plans and a new inherent reasonableness payment methodology was developed in the conference committee on the budget reconciliation bill for 1986 (Public Law 99-509).

(D) MEDICARE AND HMO'S

The new Medicare HMO Program has gotten off to a rough start. While the enrollment figures have been impressive, a number of problems have emerged in respect to access to services, misleading marketing practices, beneficiary understanding of the lock-in provision, and irregularities in enrolling and disenrolling practices. These problems are likely to require changes in law and regulation.

In March 1985, the General Accounting Office [GAO] issued a preliminary report on the Medicare's HMO demonstration projects in Florida in which it identified a lack of coordination involving payments for physician and hospital services and problems with enrollment and disenrollment procedures. These conditions resulted in coverage gaps or financial liabilities for Medicare beneficiaries.

In July 1986, the GAO issued its final report on the Florida demonstrations. It concluded that: (1) There was inadequate Federal and State oversight of HMO's that delivered services through subcontractors (clinics, physician groups, etc.); (2) Medicare payments to the HMO's were too high because they were not adjusted for enrollees' health status; (3) the HMO's failed to comply with Federal requirements that they inform enrollees of their grievance and appeal rights.

The House Select Committee on Aging held two field hearings in 1986. The first was held in New York in February and the second in July in south Florida. At the New York hearing, the committee heard testimony from representatives of the HMO industry as well as from Federal and State officials responsible for HMO monitoring and regulation. The Florida hearing included HMO industry and Federal and State government representatives. In addition, beneficiaries described difficulties they had experienced with various HMO's.

Although recently adopted Federal regulations have addressed some of the problem areas regarding HMO's, many questions remain unanswered about the HMO concept and the utilization of HMO's by Medicare beneficiaries. These include: are the HMO risk contracts saving the Medicare program money? Should the AAPCC be refined to reflect enrollees' health status? Are beneficiaries receiving adequate and timely care? Are the marketing practices of the HMO's being effectively scrutinized? Should additional safeguards be built into the Medicare Program to ensure that beneficiaries do not experience coverage gaps when they disenroll from an HMO? These are just a few of the questions that will need to be addressed in the coming year.

3. LEGISLATION AND REGULATIONS

(A) COMPREHENSIVE COST CONTAINMENT LEGISLATION

In 1986, there was little movement toward comprehensive reform of the Medicare Program. The interest in proposals like Kennedy-Gephardt (H.R. 1801; S. 1346) and the Medicare Incentives Reform Act (S. 2752), introduced by Senator Heinz in the 98th Congress, remained limited even though the 1986 report of the Medicare trustees provided a less optimistic forecast of when the trust funds would become insolvent than they did in the 1985 report. Instead, the administration and the Congress restricted their considerations to marginal cost-saving alterations in Medicare that were proposed in the overall context of deficit reduction.

(B) GRAMM-RUDMAN-HOLLINGS

Under Gramm-Rudman (Public Law 99-177), the Medicare Program is governed by a special rule limiting the amount of sequesterable funds. In fiscal year 1986, only 1-percent of benefits was allowed to be cut. (If there were to be sequesters of Medicare in future years, the cut would be limited to 2 percent.) In 1986, the overall reduction was supposed to be achieved by reducing all direct payments in equal proportion. No direct changes in beneficiary cost-sharing are allowed under sequestration, although reductions in payment for nonassigned services were most probably passed along to beneficiaries in the form of reduced reimbursement.

In 1986, a total of $230 million was sequestered from Medicare part A. Hospitals experienced a 1-percent reduction from their 1986 scheduled rates, yielding an annual increase of minus 1 percent. Another $70 million was sequestered from part B.

The operating budget of HCFA, which administers both Medicare and Medicaid, is not covered under the special Gramm-Rudman rule for health programs, and was therefore subject to the full across-the-board cut (4.3 percent in 1986). Under the fiscal year 1986 sequester, it is estimated that HCFA's administrative budget was cut by $74.5 million. This included payments to insurance companies that process and audit claims (carriers and fiscal intermediaries), payments to HMO's serving Medicare beneficiaries, the costs of program monitoring performed by the peer review organziations, provider certification, HCFA research activities and general administrative costs. Some of these cuts, such as the reduction in payments to HMO's, may over the long run undermine the faith of providers in Medicare's commitment to fair prices for services.

The 1986 sequester was small and produced a very modest cut in Medicare outlays. Future sequesters, should they occur, are unlikely to be as small. While the cuts made under sequester orders are not directly aimed at beneficiaries, there is little doubt that beneficiaries will feel their effects as providers seek to recover from beneficiaries any losses they incur from reduced Medicare payments. Moreover, hospitals—which would absorb the bulk of any future sequester—may respond by reducing access to beneficiaries as well as the quality of service to those beneficiaries. Without Gramm-Rudman, Medicare payments are not expected to rise much above current levels, despite expected inflation of 3 to 6 percent in each of the next 5 years. With it, they may experience a cut below current services.

(C) ADMINISTRATION'S FISCAL YEAR 1987 BUDGET AND REGULATORY PROPOSALS

In 1986, cost containment was again translated principally into efforts to slow the increase in Medicare outlays. There are a number of strategies that can be employed to curb Medicare outlay growth, such as reducing eligibility, reducing benefits, or increasing beneficiary cost-sharing. As in the past Reagan budgets, the Medicare budget for fiscal year 1987 incorporated all these strategies. In addition, the administration attempted to make significant changes in Medicare policy through regulation.

The administration's fiscal year 1987 budget for Medicare reflected its overall theme of curbing Government spending to reduce the Federal deficit. It also reflected the administration's long-term goal of reducing the Government's role in the provision of health services by privatizing as much of the Medicare system as possible. For fiscal year 1987 alone, the proposals would have resulted in over $4 billion in savings from current services; over the 5 fiscal years 1987–91, the proposals were estimated to save over $37 billion. In addition, general fund transfers to the Medicare trust funds would be reduced by $0.7 billion in fiscal year 1987 and by $17.2 billion through 1991 by increasing the percentage of the part B premium paid by Medicare beneficiaries. Even with these cuts, Medicare outlays were predicted to increase from about $77.5 billion in fiscal year 1987 to $115.4 billion in fiscal year 1991.

(1) Provider Cuts

The largest part of the administration's proposed cuts in Medicare would come from payments to providers, much of them through regulatory initiatives. Under the proposal, major savings would be achieved by imposing a number of sweeping changes in the way Medicare reimbursed hospitals for capital and medical education. The administration also sought a number of changes in its prompt pay and periodic interim payment policies as well as other policies that affect the flow of Medicare dollars to our Nation's hospitals. In addition, it sought substantial reductions in payments to physicians and other part B services. Of the $4.7 billion in spending cuts and premium increases, the administration proposed to achieve close to $2 billion through regulatory and management initiatives.

In reviewing these proposals, it should be noted that the fiscal year 1987 budget was issued in January, prior to the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1986 (Public Law 99-272). Many of the administration's 1987 budget proposals and regulatory actions became moot with the enactment of COBRA. Moreover, some of the savings assumed in the budget could no longer be scored as savings once COBRA became law, because final regulations had already been issued before the enactment of COBRA. This led to a major conflict between Congress and the administration about budget baseline assumptions and the timing of administration rulemaking. In OBRA of 1986, Congress attempted to head off such problems for fiscal year 1988 by enacting a moratorium on major regulations affecting hospitals and physicians in final form until September 1, 1987.[52]

(a) Hospital payments

In the January budget request, the administration indicated that it was assuming a 2-percent increase in DRG payments to hospitals, but that it would propose a formal fiscal year 1987 DRG payment update after the Prospective Payment Assessment Commission made its recommendation in April. The administration indicated that the 2-percent increase was assumed in the budget baseline.

However, major savings would be achieved through a regulatory proposal to gradually place Medicare payments of capital costs under prospective payment over the next 4 years. In addition, the administration proposed by regulation to eliminate payments for the education expenses of interns and residents while continuing payments for their salaries. It also proposed to eliminate payments to hospitals for nursing and allied health training. For indirect medical education payments, the administration proposed to reduce by half the pre-COBRA adjustment factor (11.59).

(b) Physician payments

The administration proposed a number of changes in physician payments which it planned to accomplish through regulation: revision of the Medicare Economic Index, reductions in payments for certain procedures through application of inherent reasonableness, and reductions in payments for stand-by anesthesia.

Medicare Economic Index [MEI].—Before 1984, when Congress imposed a freeze on physician payments, customary and prevailing charge fee screens were updated annually. The annual update in the prevailing charge screen had been limited to the MEI. This limit, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels. The administration proposed to revise the calculation of the MEI to account for an adjustment to the housing cost component, which the administration asserted had been historically overstated. Under the administration's plan, the MEI would be computed retroactively using the rental equivalence housing component of the CPI as a substitute for the home ownership approach.

Inherent reasonableness.—The Consolidated Omnibus Budget Reconciliation Act of 1986 required the Secretary of DHHS to promulgate regulations which specify explicitly the criteria for inherent reasonableness which are to be used in determining Medicare payments. In the 1987 budget, the administration proposed to apply inherent reasonableness guidelines to selected physician procedures in order to reduce Medicare payments for these services. DHHS issued proposed rulemaking on February 18, 1986, summarizing the conditions under which the Secretary could use the inherent reasonableness authority to establish either special methodologies or specific dollar limits when fees paid under current methods are determined to be inherently reasonable. Cataract surgery was identified as a high priced procedure for which inherent reasonableness limits should be applied.

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[52] The following summaries of the fiscal year 1987 budget proposals rely heavily on U.S. Congress, Senate Committee on Finance, Background Data on Fiscal Year 1987 Spending Reduction Proposals Under Jurisdiction of the Committee on Finance. 99th Congress, 2nd Session, S. Rept. 99-165. U.S. Government Printing Office, July, 1986.

Stand-by anesthesia.—The administration proposed to limit payments to physicians who either provide stand-by anesthesia services or administer no anesthesia while a patient is undergoing surgery.

(c) Other providers

The administration also proposed a number of changes affecting other Medicare providers:

Modify end-stage renal disease rates.—Medicare makes both a facility and a physician payment under the end-stage renal disease program for routine dialysis performed on an outpatient basis. Effective August 1, 1983, payment for outpatient dialysis has been made on a prospective basis. For routine dialysis services, the supervisory physician receives a monthly capitation rate and the facility receives a per-treatment facility rate. The administration proposed through regulation to revise the calculation of the ESRD payments. Under the proposal, physician payments would have been reduced to reflect a General Accounting Office [GAO] study on the frequency of physician visits for home dialysis patients as compared to physician services received by facility patients. Facility rates would also be reduced to reflect the most recently audited cost data for home and in-facility dialysis and a change in the composite rate formula which weights costs by the number of treatments rather than by the number of facilities.

Modify payments for return on equity.—Return on equity [ROE] capital invested and used in providing patient care is a Medicare allowable cost for proprietary health care providers. Equity capital is the net worth of a hospital or other health facility excluding those assets and liabilities not specifically related to patient care. Under the Social Security Act Amendments of 1983 (Public Law 98-21), ROE for inpatient hospital services was reduced from 150 percent to 100 percent of the rate of return on assets of the hospital insurance trust fund. The rate of return for other provider services remain at the higher rate. COBRA phases out ROE for hospitals over a 3-year period. The legislation also reduced the rate of payment for ROE for skilled nursing facilities to 100 percent of the rate of return on assets of the hospital insurance trust fund, and required that if the Secretary acts to pay for ROE for any other type of noninpatient provider, the rate of payment must also equal 100 percent of the rate of return on trust fund assets.

In the fiscal year 1987 budget, the administration proposed by regulation to eliminate the allowances for return on equity for all proprietary providers other than skilled nursing facilities and hospitals. This would principally affect home health providers.

Revise waiver of liability process.—Before OBRA of 1986, payment could be made to an institutional provider for certain uncovered or medically unnecessary services, if the provider could not have known that payment would be disallowed for those services. Hospitals, skilled nursing facilities, and home health agencies participating in Medicare were presumed to have acted in good faith (and therefore could receive payment for services later found to be uncovered or unnecessary) if their total denial rate on Medicare claims was lower than prescribed levels.

On February 21, 1986, DHHS issued regulations which would end the favorable presumption of nonliability for providers so that reimbursement would not be allowed for any uncovered or medically unnecessary services. Under the regulation, a similar waiver of liability provision for beneficiary cost-sharing liability would be retained.

Freeze clinical laboratory fees.—Payments for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed by either a physician or by a laboratory (including a hospital laboratory furnishing services to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided to a hospital's outpatients. Beginning July 1, 1984, the rates under both schedules were to be established on a regional, statewide or carrier service area basis. The fee schedules were adjusted annually to reflect changes in the consumer price index for all urban consumers. Beginning July 1, 1986, the Secretary was required to establish payment ceilings for each test to be applied nationwide. Beginning January 1, 1988, the fee schedule for tests performed by a physician or laboratory were to be established on a national basis. At the same time, payment for hospital laboratory services was scheduled to revert to cost-based reimbursement.

Under the administration's 1987 budget, the fee schedule amounts for clinical laboratory services would have been frozen for 1 year.

Part A bills.—Under current law, the responsibility for collecting deductible and coinsurance amounts from beneficiaries in connection with stays in two or more hospitals is currently assigned in the chronological order in which services are furnished. The administration proposed to assign responsibility in the order in which hospitals submit claims for Medicare payments. A hospital that provided services after another hospital but submitted its payment request first would be responsible for collecting the deductible and be credited with the first 60 days of coverage (for which no insurance is required).

Modify nonphysician payments.—Under current law, payments for durable medical equipment and certain other services and supplies are made on a reasonable charge basis under part B. The administration proposed by regulation to review reasonable charge levels and revise payments to reduce charges for nonphysician services (primarily durable medical equipment) paid for on a reasonable charge basis under part B that are determined to be excessive.

(2) Beneficiary Proposals [53]

The administration's budget contained several proposals to directly increase individual beneficiary payments. Several of these were recycled from previous administration budgets. The proposed changes in beneficiary cost-sharing were intended to increase beneficiary contributions to the costs of care, and with respect to home health services, make beneficiaries more conscious about utilization. Opponents argued that beneficiaries are now facing large out-of-pocket expenditures in connection with their medical care. In 1985, America's elderly would each spend on average $1,660 for health and long-term care—over 15 percent of their already limited incomes. Indeed, 1985 marked the first year in which the elderly spent more for their health care than they did when Medicare and Medicaid began.[54]

Part B premium increase.—Under the administration's proposal, separate premiums would be established for individual beneficiaries and third-party payers. The percentage paid by individuals would be increased over the next 5 years. Beginning with calendar year 1987, the proportion of program costs covered by the premium would rise 2 percentage points per year so that the amount the beneficiary paid would increase from 25 percent of program costs to 35 percent of program costs in 1991. For third-party payers that buy Medicare part B coverage on behalf of their beneficiaries (primarily States which pay the Medicare premium for their Medicaid beneficiaries), the premium would be set at 50 percent of costs beginning in 1987.

Apply copayments to home health care.—Under existing law, home health services are not subject to coinsurance charges. The administration's budget proposed to establish a copayment equal to 1 percent of the inpatient hospital deductible (which was estimated at the time to be $5.72 in 1987) on all home health visits, except those (1) following an inpatient hospital or skilled nursing facility stay for the treated condition or related condition, or (2) visits provided after 100 visits in a calendar year.

Increase and index part B deductible.—Enrollees in the part B portion of Medicare must pay the first $75 of covered expenses (known as the deductible) each year before benefits are paid. The amount of the deductible is fixed by law. The administration proposed to increase the part B deductible to $100 in 1987, and then index the deductible to the Medicare economic index beginning in 1988.

Delay eligibility.—Eligibility for Medicare begins on the first day of the month in which an individual reaches age 65. The administration proposed to begin Medicare eligibility on the first day of the month following the individual's 65th birthday.

This proposal would either shift costs to older individuals or to employer-based health insurance plans that may now cover persons up to age 65 or until they are eligible for Medicare. The administration argued that the initiative would not result in a gap in insurance coverage since nearly all employer-based plans generally extend protection until the beginning of Medicare coverage. This is questionable, however, given the many pre-Medicare eligible who find themselves with gaps in coverage. About 11 percent of the medically uninsured are age 55 to 64. Some portion of these people would be forced to delay for as much as a month access to Medicare.

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[53] *Ibid.*

[54] U.S. Congress, House Select Committee on Aging, America's elderly at Risk. Report presented by the Chairman, Committee Print, 99th Congress, 1st Session. Washington, U.S. Government Print, July 1985, p. vii.

Extend Medicare as secondary payer.—The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] required employers to offer their employees aged 65 through 69 the same group health plan offered to their employees under age 65. The Deficit Reduction Act of 1984 extended the provision to beneficiaries covered under a working spouses's employer-based health plan when that spouse is under age 65. The Consolidated Omnibus Budget Reconciliation Act of 1985 [COBRA] extended this provision to the working aged and spouses over age 69. Where the beneficiary elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the option to be covered only by Medicare.

The administration's 1987 budget proposed to extend the secondary payer provision to disabled beneficiaries who are also covered under their own working spouse's employer-based health plan. The provision would be enforced through the use of an excise tax on employers who do not comply. Opponents of the plan argued that it would discourage employers from retaining disabled workers. The employer community also expressed concern that it would shift more costs for health care to the private sector.

Apply cost-sharing to ambulatory surgery.—OBRA of 1980 (Public Law 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary of Health and Human Services. Payments were made on the basis of prospectively set rates as the "standard overhead amount." No beneficiary cost-sharing is required in connection with services provided in ambulatory surgical centers. The administration proposed in the 1987 budget that the standard part B coinsurance (20 percent) and deductible ($75) be imposed for ambulatory surgery services.

Establish a voluntary voucher program.—The administration also proposed legislation for a Medicare voucher plan to permit beneficiaries, at their option, to seek private alternatives to Medicare coverage. Under its plan, beginning in 1987, private plans that enroll a Medicare beneficiary would be paid premiums set at 95 percent of the Medicare AAPCC and, in exchange, would be required to provide benefits at least equivalent in value to current Medicare benefits.

Advocates for the voucher concept argued that such an approach would foster greater competition in the provision of health services to Medicare beneficiaries as well as moderate increases in health spending for the target population. Critics expressed doubts that the kinds of insurance incentives envisioned as part of such plans would in fact have much effect on either the cost or use of health services, especially among the higher risk aged and disabled population who are likely to maintain their enrollment in the basic Medicare Program.

(3) The Congressional Response

Both the House and the Senate were quick to pare down the scope and magnitude of the proposed cuts in Medicare. Indeed, because of the way in which baselines were calculated, the final congressional actions on Medicare were scored as costing the budget $1 billion in fiscal year 1987 rather than contributing to deficit reduction. Medicare had already absorbed over $30 billion in cuts between 1981 and 1986, and as noted earlier, beneficiaries were shouldering an increasingly large financial responsibility for their health care. Congress was reluctant to place additional financial burdens on the elderly by achieving Medicare cuts through cost-shifting. As in past years, the budget reductions that survived the congressional obstacle course were targeted at providers and not beneficiaries.

(D) MEDICARE AND BUDGET RECONCILIATION [OBRA]

Medicare's fiscal year 1987 budget was considered as part of the 1987 budget resolution (S. Con. Res. 120) and then as part of the Omnibus Budget Reconciliation Act of 1986 (H.R. 5300; Public Law 99-509).

For Medicare, the reconciliation process was somewhat different than in previous years. In past years, both the House and the Senate used the reconcilation process to move changes in Medicare, whether or not they had a direct impact on the budget. Under a provision of COBRA of 1986, however, the Senate functions under the "Byrd rule." Under this rule a provision is considered extraneous and thus out-of-order if it: (1) does not produce a change in outlays or revenues; (2) produces changes in outlays or revenues that result in preventing a committee from meeting its reconciliation targets; (3) it is not in the jurisdiction of the committee which reports it out; or (4) produces changes in outlays or revenues which are merely incidental to the nonbudgetary components of the provision. Provisions considered extraneous under these critieria were vulnerable on the Senate floor to a point of order which could only be overruled by a vote of two-thirds of the Senate. The Senate Budget Committee indicated to the authorizing committees that it would help to enforce the Byrd rule on the floor.

Under these constraints, the Senate Finance Committee determined that it would attempt to keep its deficit reduction package (later to be incorporated in the reconcilation bill) as free of extraneous provisions as possible. However, the chairman of the Finance Committee also indicated that another bill, H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act, would be used as a vehicle to move other, that is, extraneous, Medicare provisions later in the year. Since the House had already passed H.R. 1868, the new Senate amendments would be resolved in conference. In fact, H.R. 1868 did not make it to the Senate floor, but those Senate amendments to H.R. 1868 relating to Medicare (including several on quality) which were also in the House reconciliation bill, were considered to be part of the Senate reconciliation bill for purposes of the House-Senate conference on H.R. 5300. Consequently, to review Medicare legislation considered in 1986 by the Senate, it is necessary to look at both House and Senate actions on H.R.

5300, which became the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), and H.R. 1868.

(1) Raising Revenues for the HI Trust Fund

Under COBRA, Medicare coverage and the corresponding hospital insurance payroll tax were extended on a mandatory basis to State and local government employees hired after March 31, 1986. The Senate Finance Committee voted to extend Medicare coverage to all State and local government employees who were hired before April 1, 1986. The committee provided for an effective date of May 1, 1987 to give States a chance to prepare for the new financial burden. This provision, which was part of the Finance Committee's deficit reduction package, was accepted by the full Senate. The House, however, under pressure from States such as Texas and California where there are large numbers of uncovered State and local employees, did not include this provision in its reconciliation bill. The House position prevailed in conference on the Omnibus Budget Reconciliation Act.

(2) Provisions Affecting Hospitals

(a) Hospital rate of increase

Under the Senate proposal, the rate of increase for PPS and non-PPS hospitals would have been 1.5 percent for fiscal year 1987. Outlier payments for small rural hospitals would also have been increased. In addition, the Senate proposal required that PPS rates be restandardized, that existing rural referral centers maintain their designation for 3 years, and that the existing criteria for designation as a rural referral center be modified.

Under the House proposal, the rate of increase would have been 1 percent for PPS and non-PPS hospitals for fiscal year 1987. The House bill also specified that the fiscal year 1987 payment rate be increased by the hospital marketbasket minus 2 percent. In addition, the Secretary of DHHS was required to publish in the FEDERAL REGISTER the determination of the percent increase which would apply for fiscal year 1987, taking into account the other changes made by Congress in respect to calculating the update, and to report to Congress by April 1, 1987, providing a documented recommendation on the update factor for fiscal year 1988. The House also provided for the extension of rural referral center status for hospitals that were already so designated.

The conference agreement for OBRA included the Senate provisions with some modifications: Effective October 1, 1986, the fiscal year 1987 payment rates for PPS and PPS-exempt hospitals would be 1.15 percent. For fiscal year 1988, the Secretary is required to increase the payment rate for PPS hospitals and PPS-exempt hospitals by an update factor equal to marketbasket minus 2 percent. The Secretary will be required to adjust the DRG categories and recalibrate the DRG weights annually, beginning in fiscal year 1988, to ensure that the weights reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among DRG categories. The Secretary must provide a report with recommendations on the fiscal year 1988 update factors for PPS and PPS-exempt hospitals by April 1, 1987, and each March 1, thereafter.

Effective October 1, 1986, a separate urban and separate rural set aside factor for outlier payments would be established. Effective October 1, 1987, the methodology for computing the urban and rural averages would be revised to reflect the operating cost per discharge for the average patient as opposed to the average hospital. Finally, hospitals designated as regional referral centers as of the date of enactment would be permitted to continue their designation for three years. Criteria for eligibility for regional rural referral center status would be established by law.

(b) Capital payment reform

Capital payment reform was probably the most hotly debated Medicare issue in 1986 (see Issues), but very little was actually resolved. A plan sponsored by Senator Durenburger for placing capital under PPS was debated by the Senate Finance Committee, but under pressure from the hospital industry, the plan was scrapped in favor of a stopgap measure that would achieve budget savings but preserve the cost-based system of reimbursement. The House Ways and Means Committee chose a similar route.

The Senate's deficit reduction bill required the Secretary to reduce the amounts for capital-related payments otherwise determined to be reasonable under current law, by 3 percent for cost reporting periods beginning on or after October 1, 1986; by 5 percent for fiscal year 1988 and by 6 percent for fiscal year 1989.

The House bill would have required the Secretary to cap the aggregate amount of PPS hospital capital-related payments. The cap for fiscal year 1987 would be set at the aggregate amount of hospital capital payments in 1986 as estimated by the Secretary plus 10 percent; for fiscal year 1988 it would be limited to the aggregate amount of hospital capital payments in fiscal year 1986 plus 20 percent; and for fiscal year 1989, limited to the aggregate amount of hospital capital payments in fiscal year 1986 plus 30 percent. The fiscal year 1986 base and the allowable costs reimbursed would be adjusted to reflect the phasing-out of payments for return on equity capital. The House also included provisions relating to the publication in the Federal Register of the percentage reduction and prohibiting administrative or judicial review of the capital reduction percentage.

The conference agreement [OBRA] included the Senate provision with modifications. It required the Secretary to reduce the capital payments to PPS hospitals otherwise determined to be reasonable under current law, by 3.5 percent for fiscal year 1987, 7 percent for fiscal year 1988, and 10 percent for fiscal year 1989. Sole community provider hospitals would be exempt from the reductions; they would also not be included under a prospective payment system for capital for 3 years if one was provided by the Secretary through regulation. The agreement also stated that it was the intent of Congress to reconsider this issue in the coming year, noting that if it failed to legislate a reform, the Secretary had the authority, beginning in fiscal year 1988, to incorporate capital into PPS. The conference agreement included a prohibition on final regulations on capital until September 1, 1987. Further, it provided a clarification that if the Secretary chooses not to incorporate capital into PPS, cost-based reimbursement would continue for capital-related costs, subject to the reductions noted above.

(c) Graduate medical education

Reconciliation in 1986 was used to fine-tune the changes made in COBRA. The House proposed to reduce by 1 year the length of the initial residency which is supported by Medicare, and use the savings to encourage training in outpatient settings; the Senate had no provision in its bill. Under the conference agreement for ORBA, training would be reimbursable in outpatient settings. No change was made, however, in the initial residency period.

(3) Provisions Affecting Hospitals and Physicians

(a) PIP and prompt payment

The House bill eliminated PIP for inpatient services in PPS hospital for disproportionate share hospitals, sole community hospitals, and certain other specified facilities in waiver states. unlike the administration, the House supported continuation of PIP for PPS-exempt hospitals and other cost-based providers. The House also provided for a system of prompt payment, requiring payment of part A claims in 22 days or 'se an interest penalty would be assessed. For part B clean claim. payment would also be required within 22 days, except for participating physicians and suppliers, for whom payment would be required within 11 days. Again, failure to pay on a timely basis would result in an interest penalty.

The Senate pursued a similar strategy. PIP would be eliminated for PPS hospitals. However, the elimination of PIP would be delayed until the intermediary demonstrated that it had complied with the prompt payment requirement for at least 3 consecutive months. All cost-based providers would continue to receive PIP. The Senate's prompt payment provision stipulated that for part A and part B payment had to be made for at least 95 percent of all clean claims by 27 days in fiscal year 1987, 26 days in fiscal year 1988, 25 days in fiscal year 1989, and 24 days for fiscal year 1990 and thereafter. For claims not paid according to this schedule, interest would be paid.

The conference agreement for OBRA reflects a basic compromise between the two versions. Under the agreement, PIP will be eliminated for PPS hospitals. However, PIP will be continued for PPS hospitals with a disproportionate share adjustment percentage of at least 5.1, and for PPS hospitals with 100 or fewer beds located in rural areas. Report language accompanying the conference agreement also states that PIP should be made available by the Secretary if a hospital can demonstrate that it is experiencing significant cash flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation. PIP would be retained for other providers.

The conference agreement for prompt payment included the Senate language with a modification that 95 percent of clean claims shall be paid in not more than 30 days for fiscal year 1987; 26 for fiscal year 1988; 25 for fiscal year 1989; and 24 for fiscal year 1990 and subsequent years. This held for both part A and part B claims, except that for part B, the standard for participating physicians shall be 19 days for fiscal year 1988; 18 for fiscal year 1989; 17 for fiscal year 1990 and subsequent years.

(b) Physician payments

As described earlier (see Issues), the system for reimbursing physicians under Medicare has been subject to a number of changes over the last several years. In 1986, the House and the Senate came into conference on the reconciliation bill (H.R. 5300) with dramatically different proposals for revising the payment structure. The House bill, which incorporated two substantially different proposals—that of Ways and Means, and that of Energy and Commerce—sought to control the increase in physician charges once the freeze was lifted for both participating and nonparticipating physicians. The House also included a number of provisions directed at increasing the incentives for physicians to become participating physicians. The Senate bill reflected the administration's proposal to revise the calculation of the Medicare economic index, and the Finance Committee's concerns about the nature of the administration's study on relative value scales. The Senate bill did not incorporate any controls on physician fees. This issue was one of the most contentious of the conference committee's negotiations on the Medicare provisions.

The conference agreement for OBRA reflects the concern of the majority of conferees that in the absence of any cap or limits on physician charges, the charges for nonparticipating physicians would skyrocket once the freeze was lifted. The agreement includes the following provisions:

—Beginning in 1987, all participating and all nonparticipating physicians will receive an increase in their prevailing charge levels, above those in effect for the previous period equal to 3.2 percent. In 1988 and future years, prevailing charges would be increased by the percentage increase in the Medicare economic index [MEI]. The MEI is an economic index which reflects changes in operating expenses of physicians and in earnings levels.

—The 1 percentage point increase over the MEI, which was allowed for participating physicians for the period beginning May 1, 1986, would be built into the base for future calculations.

—The Secretary cannot retrospectively revise the calculation of the MEI. The Secretary is required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner.

—Nonparticipating physicians are subject to a limit on their actual charges.

—Where the actual charge for a nonassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, the excess of the physician's actual charge over the approved charge, and the applicable coinsurance amount.

(c) Inherent reasonableness

Congressional action on inherent reasonableness was directly linked with its resolution of the physician payment issues. On the Senate side, Senators Dole, Durenberger, and Bentsen had introduced legislation (S. 2368) to alter the process by which changes would be made by the Secretary under the inherent reasonableness authority. This legislation was reflected in the Senate reconciliation bill. The Senate, however, did not provide for any specific limits in how this authority would be applied to cataract surgical procedures or other procedures that might be identified for reductions under this authority. The House bill contained both the Ways and Means and Energy and Commerce provisions, the latter providing for specific reductions in reimbursement for cataract surgery, and payment caps on the reimbursement of nonparticipating cataract surgeons.

The conference agreement for OBRA reflects the House approach to reductions in cataract surgery reimbursement with substantial modifications. Under the agreement, the Secretary is authorized under the inherent reasonableness authority to establish a payment level for physician services based on criteria other than actual, customary, and prevailing charge for the service. Specific criteria and procedures for adjusting the payment levels are prescribed. In addition, the Secretary is required to review by October 1, 1987, the inherent reasonableness of payments for 10 of the most costly procedures paid under part B. The agreement also reduces by 10 percent the prevailing charges for cataract surgical procedures performed in 1987; in 1988, the prevailing charge is reduced by another 2 percent. In no case can the reduced prevailing charge level be lower than 75 percent of a national average prevailing charge.

(4) Miscellaneous Provider Reforms

OBRA (Public Law 99-509) also contains numerous miscellaneous changes to Medicare part A and part B that affect providers and beneficiaries. The main ones are as follows:

(a) End stage renal disease reforms

Composite rate for dialysis treatment.—OBRA prohibits the Secretary from reducing the current prospective payment dialysis rates prior to October 1, 1986. The Secretary is required to reduce the base rate for calculating the prospective payment by $2 for services furnished on or after October 1, 1986. The Secretary must maintain that rate for 2 years and is authorized to change the rate thereafter.

Study of dialysis payment rates.—The Secretary is required to provide for a study to evaluate the effectiveness of reductions in payment rates for facility and physician dialysis services and report to Congress not later than January 1, 1988.

Coverage of immunosuppressive drugs.—OBRA provides that immunosuppressive drugs furnished to a transplant patient within 1 year of the transplant are a covered service under part B of Medicare.

Reorganization of ESRD network areas.—The conference agreement requires the Secretary to establish not less than 17 ESRD network areas, and to designate a network administrative organization that includes a network council of dialysis and transplant facilities in the area, and a medical review board. The council and review board shall include at least one patient representative. The agreement also adds to the responsibilities of the networks, requires the Secretary to establish a national ESRD registry using data from networks, transplant centers and other sources, requires that the Secretary prepare an annual report to Congress on ESRD issues, and provides for funding of the networks.

Reuse of dialysis filters and other dialysis supplies.—The conference agreement requires the Secretary to establish protocols on standards and conditions for the reuse of dialysis and reprocessing filters, which will be enforceable as a condition of Medicare participation effective October 1, 1987. Beginning January 1, 1988, no reuse of blood lines, transducers, caps, and other accessories shall be allowed in Medicare ESRD facilities until and unless standards and conditions for safe reuse and reprocessing of those devices and equipment are imposed as a condition of participation.

(b) Cost limits for home health agencies

OBRA amends the Secretary's authority to establish limits for home health agency costs to require that limits be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, with an appropriate adjustment for administrative and general costs of hospital-based agencies. The Secretary is also required to base limits on the most recent data available, which may be for cost reporting periods beginning no earlier than October 1, 1983. The agreement also requires the GAO to study and report to Congress by September 1, 1987, on the appropriateness of applying per visit home health cost limits on a discipline-specific basis, rather than on an aggregate basis.

(c) Payment of parenteral and enteral nutrition supplies

The conference agreement requires the Secretary to apply the lowest charge level provision to these supplies. The Secretary is required to base payments at the 25th percentile as set forth in regulations. (This prohibits the Secretary from using "inherent reasonableness" in establishing the lowest charge level.)

(d) Payment for clinical diagnostic laboratory tests

Treatment of hospital outpatient laboratories.—The conference agreement conforms fee schedules for hospital outpatient laboratories to that for independent laboratories by eliminating the 2-percent differential and by eliminating the January 1, 1988, sunset provision on the fee schedule for such laboratory services. The 2-percent differential is retained for such laboratories if they are in hospitals that operate a 24-hour-per-day emergency room, and the laboratory is available to provide lab services for the emergency room 24 hours per day, 7 days a week.

National fee schedule.—OBRA postpones the implementation of the national fee schedule until January 1, 1990. The Secretary is required by April 1, 1988, to report to Congress on the advisability and feasibility of establishing a national fee schedule.

Competitive bidding demonstration project.—The conference agreement extends the moratorium on the demonstration project until January 1, 1988.

(e) Hospital protocols for organ procurement

The Task Force on Organ Transplantation, created by the National Organ Transplant Act (Public Law 98-507), found that opportunities for obtaining organs were lost due to shortcomings in the organ procurement process. Under the conference agreement, the Secretary is required to provide that no hospital may participate in Medicare or Medicaid unless the hospital has established protocols for encouraging organ and tissue donation. Furthermore, hospitals would have to notify the local organ procurement agency when a potential donor is identified. Those hospitals in which organ transplants are performed would also have to be members of the national organ transplant network established under the National Organ Transplant Act of 1984, and to comply with the policies of that network regarding the allocation of organs. The agreement also extends these requirements to tissue donation. Finally, OBRA prohibits payment under Medicare or Medicaid for the costs of procuring organs if the procurement organization does not meet certain criteria and performance standards, including specified procedures for allocating organs to United States versus foreign nationals.

(f) Ambulatory surgery

Under current law, Medicare may pay for ambulatory surgery in three settings: an ambulatory surgical center (reimbursed according to rates known as the "standard overhead amount"); hospital outpatient department (reimbursed on the basis of reasonable costs); physician's offices (not yet implemented by DHHS). When surgery is performed in any of these three settings, Medicare reimburses 100 percent of the physician's reasonable charges, provided the physician agrees to accept assignment.

Under the conference agreement, a new payment methodology for facility services provided by hospital outpatient departments in connection with ambulatory surgery would be established beginning October 1, 1987. This will evolve into a fully prospective system by October 1, 1989. In addition, OBRA requires PRO review of all ambulatory surgical procedures or, at the Secretary's discretion, a sample of selected procedures. It also provides for the repeal of the current law provisions waving coinsurance and deductible provisions (i.e., beneficiaries will be liable for the standard 20 percent copayment and $75 deductible). Finally, the agreement calls for the Secretary to submit a report to Congress by April 1, 1989, on issues relating to the prospective rate setting methodology for ambulatory surgery in hospital outpatient departments, and for the Secretary to develop a model system for prospective payment of outpatient department services other than ambulatory surgical procedure and submit a report to Congress on the model by January 1, 1991.

(g) Vision services

OBRA includes a provision allowing Medicare payment for vision care services performed by optometrists, if the services are among those already covered by Medicare when furnished by a physician and if the optometrist is authorized by State law to provide the services. The provision is effective for services furnished on or after April 1, 1987.

(h) Occupational therapy services

Effective July 1, 1987, Medicare will pay under B for occupational therapy serices provided in skilled nursing facilities (when part A coverage has been exhausted), in a clinic, rehabilitation agency, or public health agency. The conference agreement also extends part B coverage to occupational therapy services furnished by an independently practicing therapist in a therapist's office or a beneficiary's home. A physician must certify the need for such services and a treatment plan must be established by a physician or by the qualified occupational therapist.

(i) Services of a physician assistant

The conference agreement authorizes Medicare coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, intermediate care facility or as an assistant-at-surgery. The agreement sets limits on Medicare reimbursement for these services.

(5) Provisions Affecting Beneficiaries

(a) Part A deductible reform

In January 1986, the administration's budget indicated that the part A deductible was expected to climb from $490 to $572, effective January 1, 1987. This 16-percent increase was coming on top of a 23 percent hike for the previous year and reflected the out-of-date formula linking increases to the average cost per day of a hospital stay. The same formula influences the coinsurance amount for post-hospital extended care services and the monthly part A premium, since these amounts are directly linked to the part A deductible. As length of stay has declined, the average cost per day has shot up even though the actual increase in the cost per admission has been more moderate. Senator Heinz introduced legislation (S. 2341) to reform the calculation of the deductible, and together with Senator Kennedy, was also successful on the floor of the Senate in getting a firm commitment from the Chairman of the Finance Committee that the committee would include a formula change and a reduced 1987 deductible ($520) in its 1987 reconciliation bill.

This commitment was, in fact, reflected in the Senate's reconciliation package. Under the Senate bill, the inpatient deductible for 1987 would be set at $520. For successive years, the Senate bill set the deductible to an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the same percentage that applied to PPS payment rates and adjusted to reflect changes in real case mix (the final amount rounded to the nearest $4.00).

The House chose a different strategy. Under the Ways and Means provision of the House reconciliation package, the part A deductible for 1987 would be held to $500. The House bill did not treat the formula, leaving the current law formula in place for future years.

The conference agreement for OBRA incorporated the Senate language with modifications to clarify current law. For 1987, the part A deductible was set at $520. In subsequent years, it will be adjusted by the applicable percentage increase for hospital payments under Medicare's PPS adjusted to reflect changes in case mix. The agreement also clarified current law as to how the part A deductible is to be assessed for patients with a hospital stay which falls into 2 calendar years.

(b) Changing Medicare appeal rights (part B)

Before OBRA, beneficiaries dissatisfied with a carrier's disposition of a part B claim were entitled to review by the carrier. A fair hearing by the carrier was then available if the amount in controversy was $100 or more. The law did not provide for any further administrative appeal or judicial review of the part B claim.

In 1985, an attempt by a coalition of beneficiary and provider groups to expand part B appeal rights led to an amendment to COBRA which, at the insistence of OMB, was struck out at the last moment. In 1986, the coalition was successful in getting the House to include a modified version of the provision in its deficit reduction package. The Senate took no action but agreed to the House version with changes in the conference agreement on OBRA.

OBRA provides that beneficiaries may obtain an administrative law judge hearing if the amount in controversy is $500 or more and judicial review if the amount in controversy is $1,000 or more. In determining the amount in controversy, the Secretary under regulations must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals. Carrier hearings are retained for amounts in controversy between $100 and $500. The provision also defines the circumstances in which coverage determinations and payment methodologies would be subject to judicial review. It applies to items and services furnished on or after January 1, 1987.

(c) Medicare as secondary payer for the disabled

In response to the administration's budget proposal, the Senate included a provision to require that Medicare become the secondary payer for all Medicare beneficiaries (including the disabled and those who buy into Medicare), who elect to be covered by employment based health insurance as a current employee (or family member of such employee) of a large employer. The OBRA provision specifically brings disabled beneficiaries under the secondary payer provision, but only applies to employers with 100 or more employees. The agreement also requires the Secretary to study the impact of this provision.

(6) Major Studies

The conference agreement for OBRA included a number of new studies to be completed by DHHS. Most significant are the following:

(a) Establishment of research program on practice variations

The Congress has become increasingly concerned about the vast variations in the utilization of medical services by comparable populations. This concern was reflected in both the House and the Senate deficit reduction packages by provisions for a major DHHS research effect on practice utilizations. Under the conference agreement, the Secretary is required to provide for a research program on patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness. In selecting treatments and procedures to be studied, the Secretary is required to give priority to those medical and surgical treatments and procedures (1) for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographical areas; and (2) which are significant (or potentially significant) for purposes of learning about utilization by Medicare beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the program and risk involved for the beneficiary. The agreement includes authorization of funding out of the hospital insurance trust fund: $4 million in fiscal year 1987; $5 million for fiscal year 1988; and $5 million for fiscal year 1989; and from the supplementary medical insurance trust fund: $2 million for fiscal year 1987; $2.5 million for 1988; and $2.5 million for 1989. The research program is to be run by the National Center for Health Services Research and Health Care Technology.

(b) Alzheimer's disease demonstration projects

Under current law, Medicare beneficiaries with Alzheimer's disease or related disorders are covered for acute medical care services they might need. However, many of the home and community-based services which these persons require in order to remain in their homes are not covered by Medicare.

Under the conference agreement for OBRA, the Secretary may conduct up to 10 demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders. Services provided under the demonstration projects must be designed to meet the specific needs of Alzheimer's disease patients and may include case management, home and community-based services, mental health services, outpatient drug therapy, respite care and other supportive services and counseling for family, adult day care services and other inhome services. $40 million is to be appropriated for these projects. The demonstration projects are to be funded from the Medicare part B trust fund, without being charged against the monies appropriated for the research activities of the Health Care Financing Administration.

Each demonstration project would be conducted over a period of 3 years and at sites chosen so as to be geographically diverse and located in States with a high proportion of Medicare beneficiaries. The projects must provide each Medicare beneficiary with comprehensive medical and mental status evaluation upon entering the project and at discharge. Projects should also involve community outreach efforts at each site to enroll the maximum number of Medicare beneficiaries in each project. In addition, the Secretary must provide for an evaluation of the projects and submit to Congress two reports: a preliminary report during the third year of the project and a final report upon completion that includes recommendations for appropriate legislative changes.

(7) Proposals Rejected By Congress

The Congress rejected almost all of the administration's proposals affecting Medicare beneficiaries, and as described above, greatly modified the administration's proposals affecting providers. Most of the beneficiary measures had been advanced before by the administration; it is therefore not surprising that Congress did not give them much serious consideration.

The rejected beneficiary proposals include: (1) Copayments for home health care; (2) one-month delay in eligibility for Medicare benefits; (3) increase and index the part B deductible; (4) voluntary voucher program; and (5) increase and modify the part B premium. Congress also rejected the administration's proposals to place capital under PPS (although the Congress is likely to revisit this issue in 1987), to eliminate the end stage renal disease networks and to substantially modify and reduce direct and indirect Medicare payments for medical education. Most of the other administration proposals affecting providers, such as the plan to reduce physician payments through inherent reasonableness regulations, met substantial congressional resistance. While the administration's provider proposals provided a catalyst for change in these areas, the basic policies were worked out in negotiations between the House and Senate in the conference committee on the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).

(E) QUALITY OF CARE LEGISLATION AND REGULATIONS

On April 17, 1986, Senator John Heinz and Representative Pete Stark introduced the Medicare Quality Protection Act (S. 2331, H.R. 4638). The legislation received broad bipartisan support on both sides of the Hill, as reflected in its diverse set of Senate and House cosponsors. S. 2331/H.R. 4638 was drafted in response to the many problems with quality and access to care that were uncovered in the Senate Aging Committee's investigation into quality of care under Medicare's prospective payment system.

The House Ways and Means Committee held a hearing on the legislation on April 23, 1986; soon after, its Subcommittee on Health marked up the bill with revisions which were later incorporated into the full committee's reconciliation package, and the House reconciliation bill (H.R. 5300). The Senate Finance Committee held a hearing on the general issues related to quality of care on June 3, 1986. The committee then incorporated, with some revisions, most of S. 2331 in its reconciliation package. Those provisions that were considered extraneous under the Byrd rule were incorporated in the Finance Committee's amendments to H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act. The conference agreement for H.R. 5300, the Omnibus Budget Reconciliation Act (Public Law 99-509), incorporates a large portion of the Heinz-Stark bill. The provisions affect services under Medicare part A, part B, and the peer review organizations.

(1) Improving Quality of Care in Respect to Part A Services

(a) Refinement of PPS

Under PPS, hospitals are paid a predetermined rate based on 471 DRG's. The patient is classified into a DRG, based on his or her primary diagnosis, secondary diagnosis, primary procedure, age and discharge status. There is no adjustment for the severity of the patient's illness or the complexity of the patient's case within the appropriate DRG.

Under the conference agreement, the Secretary is required to submit to Congress within 2 years of enactment a specific legislative proposal to improve the classification and payment under PPS (including the system for payment of outliers) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions. It also requires the Secretary, in developing the proposal, to account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(b) Requiring notice of hospital discharge rights

Prior to OBRA there was no statutory requirement that a statement of patient rights be distributed. As a result of OBRA, hospitals are required to provide to each beneficiary (or to a legally responsible person acting on the beneficiary's behalf), at or about the time of the beneficiary's admission as an inpatient, a written statement which explains (1) the beneficiary's right to Medicare benefits for inpatient hospital services and for post-hospital services, (2) the circumstances under which the beneficiary will and will not be liable for charges for a continued hospital stay, (3) the beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and (4) the beneficiary's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides any additional information the Secretary may provide. The Secretary must prescribe the notice language no later than 6 months after the date of enactment, and must be provided by the hospitals within 60 days of the date the language is first prescribed.

(c) Requiring hospitals to provide a discharge planning process

By regulation, hospitals participating in Medicare were required to have a discharge planning program to facilitate the provision of follow-up care. However, Congress determined that this requirement was inadequate to ensure appropriate discharge planning services. The conference agreement for OBRA requires (a) hospitals as a condition of participation for Medicare to have a discharge planning process; (b) hospitals to follow specific guidelines and standards for discharge planning that are established by the Secretary. These guidelines and standards must include the following: (1) the hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning; (2) the hospital must provide a discharge planning evaluation for the identified patients and for other patients upon the request of the patient's representative, or patient's physician; (3) any discharge planning evaluation must be made on a timely basis to ensure that appropriate post-hospital care will be made before discharge and to avoid unnecessary delays in discharge; (4) a discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services; (5) the discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative); (6) upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient; (7) any such discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel. Flexibility shall be allowed for small rural hospitals.

The agreement includes a requirement that standards for hospital accreditation (such as JCAH) can only be used to accredit a hospital's discharge planning program if they are at least equivalent to the standards listed above. This provision is effective 1 year after enactment. OBRA also requires the Secretary to arrange for a study of the adequacy of the standards used for hospitals, for the purpose of meeting Medicare's conditions of participation in assuring the quality of services furnished in hospitals. The Secretary is required to report to Congress on the results of the study no later than 2 years after enactment.

(d) Study of payment for administratively necessary days

Under current law, Medicare makes no special provision for separate payment for a day of continued inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility. These types of days are referred to as administratively necessary. The conference agreement for OBRA: (1) requires the Secretary to conduct a study to determine whether a payment should be made (in a budget-neutral way for PPS hospitals) to a hospital for administratively necessary days, separate from the DRG and outlier payments; (2) requires the Secretary, in conducting the study, to consider the need for such a payment to minimize the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and difficulties resulting from the source of payment for such care. It also requires the Secretary, in conducting the study, to consider the need for a payment to minimize the risk of inappropriate discharge to a noninstitutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility. The Secretary is required to report to Congress on the results of the study no later than January 1, 1988.

(e) Continuing waiver of liability for SNF's, home health agencies, and hospices

As a result of COBRA, the favorable presumption of liability for SNF services is extended through October 7, 1988. For home health agencies, COBRA continued it until 12 months after claims processing for home health agencies has been consolidated under 10 regional intermediaries. The conference agreement for OBRA does not affect the sunset of the waiver for SNF's and home health agencies; it does, however, provide for application of the favorable presumption of liability rules to hospice providers through November 1, 1988.

(f) Extension of waiver of liability provisions to certain coverage denials for home health services

Prior to OBRA, the waiver of liability protection for home health providers did not apply to noncovered home health services if the reason for the denial was because the patient was determined not to be confined to his home or not to need skilled nursing care on other than an intermittent basis. Denials of these kinds are referred to as technical denials. OBRA extends the waiver of liability to these technical denials except those based on possible need for speech or occupational therapy. The provision becomes effective July 1, 1987.

(g) Development of uniform needs assessment instrument

OBRA requires the Secretary to develop an uniform needs assessment instrument that (1) evaluates the functional capacity of an individual, the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and the social and familial resources available to the individual to meet those requirements; and (2) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health related or supportive nature. The Secretary may develop more than one such instrument for use in different situations.

In addition, OBRA requires the Secretary to develop the needs assessment instrument in consultation with an advisory panel appointed by the Secretary. The panel is to include experts in the delivery of post-hospital extended care services, home health services, and long-term care services, and is to include representatives of hospitals, physicians, skilled nursing facilities, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries. The Secretary is required to report to Congress no later than 1 year after enactment on the instrument(s) developed.

(h) Including in PPS annual reports information on quality of post-hospital care

Prior to OBRA, the Secretary was required to report annually on the impact of the prospective payment methodology for inpatient hospital services through 1987. The conference agreement for OBRA extends the requirement for annual reports through 1989 and requires the reports to include (1) an evaluation of the adequacy of the procedures for assuring quality of Medicare post-hospital services; (2) an assessment of problems that have prevented Medicare beneficiaries from receiving appropriate post-hospital services; and (3) information on Medicare reconsiderations and appeals for payment for post-hospital services. The provision is effective for reports beginning with 1986.

(i) Prior authorization demonstration project

Under current law, Medicare fiscal intermediaries have responsibility for determining whether payment will be made for services provided by home health agencies and SNF's. These decisions are generally made on a retrospective basis after services are provided. OBRA requires the Secretary to conduct a demonstration program concerning prior authorization for SNF and home health services, which shall consist of four projects implemented no later than January 1, 1987. The Secretary is required to evaluate the demonstration and report back to Congress by February 1, 1989.

(2) Improving Quality of Care in Respect to Part A and Part B Services

(a) Provider representation of beneficiaries on appeals and appeals of technical denials

If a beneficiary disagrees with a payment denial for services provided under Medicare part A, he or she is entitled to appeal the determination. In the past, beneficiaries have been permitted to be represented in their appeals by the provider who furnished the services in question. However, in April 1984, HCFA issued an intermediary manual instruction prohibiting such representation. HCFA also has prohibited appeals of "technical" denials, such as homebound and intermittent care requirements for home health services.

Under the conference agreement for OBRA, providers are allowed to represent beneficiaries on appeals. However, the new law prohibits providers who do represent beneficiaries from imposing any financial liability on the beneficiary in connection with the representation. It also prohibits costs incurred by providers in representing the beneficiary from being charged to Medicare. Finally, OBRA permits beneficiaries the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria.

(b) Prohibition of certain physician incentive plans

Section 1866(d) of the Social Security Act provides for Medicare payments to most hospitals on a prospective basis. These PPS hospitals are responsible for the costs of all medically necessary part

A inpatient services provided to Medicare beneficiaries during their inpatient stay. Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], provides for Medicare payments to Health Maintenance Organizations [HMO's] and Competitive Medical Plans [CMP's] on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the costs of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

The conference agreement for OBRA prohibits a hospital from knowingly making incentive payments to a physician as an inducement to reduce or limit services provided to Medicare or Medicaid beneficiaries who are under the direct care of the physician. Hospitals who knowingly make such payments are subject to civil monetary penalties of $2,000 for each such individual with respect to whom the payments are made, in addition to any other penalties that may be prescribed by law. Any physician who knowingly accepts such incentive payments is also subject to a civil money penalty of $2,000 for each such individual with respect to whom such payments are received, in addition to any other penalties prescribed by law.

HMO's and CMP's that serve Medicare patients are exempt from this prohibition through April 1, 1989. The Secretary is required to conduct a study of physician incentive arrangements and make legislative recommendations to refine the prohibition as it relates to HMO's and CMP's by January 1, 1988. The prohibition does not apply to incentive plans approved by the Secretary as part of a demonstration project.

(c) Study to develop a strategy for quality review and assurance

OBRA attempts to fill a major void in the quality research agenda of DHHS. Under the conference agreement, the Secretary is required to arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under Medicare. The agreement provides specific guidelines on the scope and nature of the study: It should (a) identify the appropriate considerations which should be used in defining "quality of care;" (b) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care; (c) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done; (4) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care; (e) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress; (f) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care; (g) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and (h) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

The Secretary is required to report to Congress on the study no later than 2 years after the date of enactment. The report shall address the items described above and shall include recommendations with respect to strengthening quality assurance and review activities for Medicare services. The Secretary is also required to designate an office with responsibility for coordinating the planning of studies on quality of care, including the development of priorities for quality studies. The office shall be responsible for coordinating access to data necessary to conduct the studies and for maintaining a clearinghouse on PPS quality studies conducted by HHS and other entities. This office may be located within the Health Care Financing Administration.

(3) Improving Quality of Care—Peer Review Organizations

(a) PRO review of hospital denial notices

Prior to OBRA, hospitals were authorized by regulation to make determinations that further inpatient care was no longer medically necessary. If the attending physician concurred with this determination, the hospital had the right to serve the beneficiary with a discharge notice and to begin to charge for the continued stay beginning with the third day after serving the notice. The beneficiary had the right to appeal the discharge notice to a peer review organization [PRO]. If the PRO reversed the hospital's determination, the hospital could not bill for continued inpatient stay. The PRO was required to decide the appeal within 3 working days after the receipt of the appeal. As a result of this policy, a beneficiary could incur financial liability for several days of continued stay before receiving notice of the PRO's decision in the event of an adverse decision.

Under the conference agreement for OBRA, the process for PRO review of hospital denial notices has been revised. OBRA:

—Provides that if a hospital determines and the physician agrees that the patient no longer requires inpatient care, the hospital may provide that patient with a coverage denial notice.

—Provides that if a hospital has determined but the physician does not agree that the patient no longer requires inpatient care, the hospital may request the PRO to review the validity of the hospital's determination.

—Provides that if a patient has received a denial notice and requests the PRO to review the determination, the PRO shall conduct a review of the validity of the hospital's determination and shall provide notice to the patient, hospital, and attending physician. Such review is to be provided regardless of whether or not the hospital will charge for continued care or whether or not the patient will be liable for payment for continued care.

—Provides that if the patient requests a review while still an inpatient and not later than noon of the first working day after receipt of the hospital denial notice, the hospital must provide the PRO with the records required to review the determination by the close of business of such day, and the PRO must provide notice by not later than 1 full working day after it has received the request and the records.

—Provides that if the patient has made a timely request, and the patient did not know and could not reasonably have been expected to know that continued inpatient stay was not necessary, the hospital may not charge the patient before noon of the day after receipt of the PRO's decision.

—Requires PRO's in conducting reviews to solicit the views of the patient.

(b) PRO review of inpatient hospital services and early readmission cases

PRO's review the necessity and quality of hospital services provided to beneficiaries, but before OBRA, the nature of the review was specified through regulation and there was no statutory provision regarding timely provision of data to the PRO's by Medicare's fiscal intermediaries. Under OBRA, the Secretary is required to provide that fiscal intermediaries furnish the necessary data to the PRO's. If the Secretary determines that a fiscal intermediary is unable to furnish the information on a timely basis, he may require the hospital to do so.

OBRA also requires PRO's to perform early readmission reviews to determine if the previous inpatient hospital services and post-hospital services met professionally recognized standards of health care. (Review of services provided by physicians in an office setting are excluded from PRO review until January 1, 1989.) The reviews may be done on a sample basis if the PRO and Secretary determine it to be appropriate. Any early readmission case is defined as one where a readmission occurs within 31 days of discharge.

(c) Requiring PRO review of quality of care

PRO's are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and meet professionally recognized standards of care. COBRA required PRO's to review services provided by health maintenance organizations [HMO's] and competitive medical plans [CMP's] effective January 1, 1987. A required level of effort for PRO review of HMO and CMP services is not specified.

Under OBRA, each PRO is required to provide that a reasonable proportion of its activities are involved with reviewing the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including inpatient hospital care, post-acute care settings, and ambulatory settings). This provision is delayed for 2 years as it pertains to physician offices. For health maintenance organizations and competitive medical plans, OBRA delayed PRO review until April 1, 1987, and provided that in half of the States, the Secretary shall seek bids for the quality review contracts on a competitive basis. In the other 25 States, PRO's would do the reviews. No more than 50 percent of the total number of beneficiaries enrolled in HMO's or CMP's can be included in the States that are subject to competitive bidding.

In addition, the Secretary is required to provide data (and associated data processing support) to at least 12 PRO's to enable each PRO to review and analyze small area variations in the utilization of hospital and other health services within the PRO's service area. The PRO's shall use the small area variation information in establishing priorities for review activities and in conducting educational programs for community physicians.

(d) Requiring consumer representation on PRO boards

OBRA requires at least one consumer representative on PRO boards. There was no requirement prior to OBRA's enactment.

(e) Improve peer review responsiveness to beneficiary complaints

Under the conference agreement, if the PRO makes a final determination with respect to whether the services which are the subject of a complaint did or did not meet professionally recognized standards of care, the PRO would be required to inform the beneficiary involved (or the beneficiary's representative) of any final action taken. Before the PRO concludes that the services involved did not meet professionally recognized standards of care, the PRO would be required to provide the practitioner (or other person concerned) with reasonable notice and opportunity for discussion. There was no statutory requirement for responding to beneficiary complaints prior to OBRA.

(f) Sharing of information by PRO's

PRO confidential information has been subject to protection. However, under OBRA, confidential information, relating to a specific case or possible pattern of substandard care, obtained by PRO's can be shared, upon request, with a State licensing or certification agency or with a national accreditation body, but only to the extent that such information is required by such agency or body to carry out official functions.

(g) Funding of PRO activities

The costs of PRO review are funded by transfer of funds from the Federal Hospital Insurance Trust Fund. Prior to OBRA, the aggregate amount to be paid to all PRO's during a year could be no less than the aggregate amount expended during fiscal year 1986 on PRO reviews adjusted for inflation.

OBRA requires hospitals, skilled nursing facilities and home health agencies to maintain an agreement with the appropriate PRO with respect to review of services provided by hospitals, skilled nursing facilities or home health agencies (other than inpatient hospital services) and with respect to review of beneficiary complaints regarding quality. The activities are to be considered a cost of providing services and are to be paid directly by the Secretary to the PRO. Payments are to be transferred in appropriate amounts from the part A and part B trust funds and shall not be less in the aggregate than the amount determined by the Secretary to be sufficient to cover the costs of specified review activities. Similar provisions apply with respect to HMO's and CMP's.

(E) HMO LEGISLATION

In 1986, there was major legislative activity affecting Medicare HMO's, as well as HMO's more generally. COBRA (Public Law 99-272), defined responsibility for payment when a beneficiary is an inpatient of a hospital and chooses to enroll in or disenroll from a TEFRA HMO/CMP. If the enrollee is an inpatient on the effective date of his/her enrollment in a HMO, Medicare will be responsible for reimbursing the hospital for the full inpatient stay. The HMO will be responsible for any other services covered under Medicare beginning on the effective date of enrollment. The opposite applies if a beneficiary disenrolls from a HMO during an inpatient hospitalization. Under these circumstances, the HMO is responsible for payment for the full inpatient stay. It is not responsible for any other covered Medicare services beginning on the effective date of disenrollment.

Other provisions in COBRA defined the effective date of disenrollment from a HMO as being the first day of the first month following the month in which the disenrollment request was made. Also, COBRA included language which requires HCFA to review all HMO marketing materials 45 days prior to their use. Finally, DHHS is required to publish the AAPCC no later than September 7 of each year.

Congress also included a number of charges in OBRA for 1986 (Public Law 99-509) affecting Medicare HMO's. Many of these provisions were inspired by the problems emerging with risk contracts. OBRA: (1) Eliminates the "2 for 1" conversion rule for non-risk HMO Medicare enrollees. This required HMO's to enroll two new risk beneficiaries for every one converted from the cost to the risk method of payment; (2) requires that Medicare HMO's provide enrollees a full explanation of their rights of benefits at the time of enrollment and not less frequently than annually; (3) restricts the issuance by DHHS of the 50-50 waiver requirement which limits the number of Medicare versus non-Medicare enrollees in HMO's; (4) sets forth a prompt payment standard for claims within the same time limits that apply to Medicare carriers and intermediaries; (5) provides DHHS with direct access to financial records and disclosure of internal loans made between a HMO and subcontractors, affiliates, and related parties. In addition, HMO's that fail to provide medically necessary items and services can be fined up to $10,000 for each failure; (6) requires DHHS to conduct a study in order to refine the AAPCC or method in which the capitated monthly rate per beneficiary is calculated; (7) provides that effective June 1, 1987, beneficiaries will be able to disenroll from HMO's at their local Social Security offices; (8) allows HMO's to offset moneys lost through the 1 percent reduction of payments in 1986 (due to Gramm-Rudman) by use of their benefit stabilization funds; (9) prohibits physician incentive plans that encourage reduction of Medicare services. This ban is scheduled to begin in 1989.

Federal support for HMO's.—During 1986, legislative activity occurred that will have implications for non-Medicare HMO's. Under the Omnibus Health Act of 1986 (S. 1744, Public Law 99-660), many of the Federal incentives for HMO development are eliminated. S. 1744 was passed by the House and Senate on October 17 and 18, 1986, respectively and was signed into law by President Reagan on November 14, 1986. Feasibility surveys and grants, contracts and loan guarantees for planning for initial development, as well as health systems agency review of HMO applications have been terminated. In addition, loan or loan guarantees given to help meet the initial costs of HMO operations cannot be made unless DHHS had made a grant or loan or contracted to guarantee a loan during fiscal year 1981 through 1985. The legislation also eliminates authority for loans and loan guarantees for acquisition and construction of ambulatory care facilities. HMO's will no longer need to demonstrate on a periodic basis that they are complying with conditions for asssitance. In addition, within 18 months of enactment of this legislation, DHHS is required to submit a study that will assess the HMO provisions of the Public Health Service Act. Additionally, psychologists will now be able to provide services for HMO's members.

(F) MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT

In response to the problems addressed at the Senate Special Committee's hearing on unfit physicians, Chairman Heinz and Senator Glenn of the Aging Committee introduced S. 837, the Medicare and Medicaid Patient and Program Protection Act of 1985, which would have significantly expanded the Federal Government's authority—and the States' authority—to exclude health care practitioners from Medicare and Medicaid. This bill would also have established a minimum exclusionary period of 5 years, instituted better coordination between Federal agencies and State sanctioning boards, imposed reporting requirements on State licensing authorities, and strengthened civil and criminal penalties. A similar bill, H.R. 1868, was introduced in the House by Representative Henson Moore. In addition, Senator Roth, by request, introduced S. 1323, a modified version of the other bills which adds additional sanctioning authority recommended by DHHS.

H.R. 1868 was passed by the House on June 4, 1985. All three bills were reviewed at a Senate Finance Committee hearing on July 12, 1985. On October 2, 1986, the Finance Committee reported out an amended version of H.R. 1868, which combined elements of S. 837, S. 1323 and the original version of H.R. 1868,[55] The bill as reported by the committee also contained several Medicare and Medicaid Program changes not related to unfit physicians. H.R. 1868 fell victim to the heavy Senate schedule in the waning days of the 99th Congress, and did not make it to the Senate floor.

4. PROGNOSIS

Medicare emerged out of the fiscal year 1987 budget battles in far better shape than most would have predicted early in the year. The administration's original budget proposed about $4.7 billion in cuts for fiscal year 1987 and $23 billion over 3 years. The reconciliation bill (Public Law 99-509) is actually expected to cost $1 billion in additional Medicare outlays for 1987 and about $3 billion for 1987 through 1989. Costs to beneficiaries were actually reduced as a result of the change in the part A deductible, and benefits were incrementally expanded in the form of increased coverage for vision care and other services.

Congress made little or no progress, however, in moving toward comprehensive reforms of the Medicare Program, leaving part B of the program in particular, dangerously vulnerable to new budget cutting efforts in the future. While Medicare is shielded from the full force of Gramm-Rudman-Hollings, it nevertheless would play a very major role in any sequester, should one occur. Whichever budget reduction process is pursued, Medicare and its 30 million beneficiaries are likely to be participants in a painful process of belt-tightening and program retrenchment.

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[55] U.S. Congress, Senate Committee on Finance. Medicare and Medicaid Patient and Program Protection Act of 1986. Report to Accompany H.R. 1868. Senate Report No. 99-250, 99th Congress, 2d Session. Washington, DC, U.S. Government Printing Office.

Medicare is expected to purchase quality health care for its beneficiaries. The meaning of quality, however, is poorly defined. What is clear is that quality care represents more than the absence of avoidable death, unnecessary surgery, serious complications, or unnecessary hospital readmissions. These criteria represent the scope of current quality objectives defined by HCFA.

A balanced assessment of quality of care requires attention to both process and outcomes. Critical questions are what changes in the processes of hospital care are taking place as a result of PPS and what is the relationship between those processes and patient outcomes? PPS will affect the quality of care in both positive and negatives ways. It may also contribute to major shifts in the location of care, as patients receive more and more of their care in post-hospital and ambulatory care settings. This will result in significant shifts in costs from Medicare part A to Medicare part B and to beneficiaries. Any comprehensive evaluation of the impact of PPS along these lines will be time-consuming, but it is very necessary if we are to make informed decisions about health policy in this Nation.

This country has little experience with measuring the effects of reimbursement changes on quality of care. A thorough assessment of PPS can be made only after a substantial time period has elapsed. The time to establish appropriate data collection strategies and monitoring systems so that information is available for such assessments is past due.

There are several obstacles to achieving an accurate and balanced view of the impact of PPS (e.g., limitations of existing data bases, the presence of multiple, simultaneous changes in the health care system, etc.) Nevertheless, significant efforts need to be directed toward measuring the extent to which PPS has met its objective. The Omnibus Reconciliation Act of 1986 (Public Law 99-509) provides DHHS with new responsibility and authority for quality assurance and assessment. It is imperative that the Department implement these provisions as intended by Congress.

The Medicare Program faces difficult times ahead. With budget cuts ratcheting down reimbursement rates for providers, pressures will increase to deliver care at the lowest cost possible. In the absence of careful and constant monitoring, providers may reduce care at the same time that they are reducing costs—at the expense of America's senior citizens. The success of PPS rides on the willingness of patients, providers, and regulators to get the most out of an increasingly lean system. In 1985, the Congress helped to spotlight the many problems developing under PPS with quality and access to care; in 1986, the Congress provided for changes in the Medicare Program to respond to the most glaring quality and access problems developing under PPS. In 1987, Congress will face new challenges as it seeks to respond to concerns about access, quality and the need for catastrophic health insurance protection in an environment in which deficit reduction continues to take priority on the national policy agenda.

B. HEALTH BENEFITS FOR RETIREES OF PRIVATE-SECTOR EMPLOYERS

1. OVERVIEW

In recent years there has been increasing recognition of the role that employers play in providing health benefits to retirees through their group health insurance plans for active workers. While a relatively small percentage of retirees are currently covered by employer plans, retiree health benefits are important for those who have them. With increasing awareness of the importance of this benefit to retirees has come a growing concern about the lack of benefit security. At the same time, growing cost pressures for employers and the threat of tremendous unfunded long-term liabilities for health benefits have raised employer anxieties about the future viability of retiree health benefits.

Many of these issues were brought to the attention of the Congress in 1986 when the LTV Corp. unilaterally terminated health and life insurance benefits for their 78,000 retirees as they filed for reorganization under chapter 11 of the Bankruptcy Code. As Congress rushed to secure these benefits for LTV's retirees, it came face-to-face with the difficult reality of this large, unsecured and unfunded, promise to current and future retirees.

2. BACKGROUND

Employer- or union-sponsored retiree health benefits are group health insurance plans which provide coverage for retirees not yet eligible for Medicare, and which supplement Medicare benefits for retirees age 65 and above. Medicare is the fundamental health benefit for retirees, covering over 26 million older persons—almost every American over the age of 65. Medicare does not by itself meet all of the critical needs of retirees over 65. Also, Medicare coverage is not available to retirees younger than age 65.

Presently, coverage of retirees under employer group plans is not widespead. A report issued in 1986 by the Department of Labor estimated that 1 out of every 6 Americans age 65 or older is receiving a portion of their health coverage from an employer or union. An estimated 6.9 million retirees are covered by private employer- or union-sponsored health plans. Of these, 4.3 million are age 65 or older and 2.6 million are under age 65.

For those who have employer-provided coverage, however, the benefit is important. A major aspect of the benefit is simply the opportunity to continue participating in the employer's group after retirement rather than being forced to purchase an individual health insurance policy. The cost of purchasing an individual policy before age 65 may be prohibitive, and retirees may have difficulty finding an insurance company that is willing to offer them coverage if they have some pre-existing medical condition. Through lower administrative costs and high employer contributions, group insurance typically offers beneficiaries a higher range of benefits at a lower cost than persons with nongroup insurance can obtain.

Retirement medical benefits are most often provided by large employers. According to survey data collected by the Washington Business Group on Health, approximately 8 out of 10 large employers provide postretirement health coverage.

Those employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. At that point, most corporations provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare. One of 2 approaches may be used: A "carve-out," a "coordination of benefits" plan or a "Medicare supplement." The "carve-out" continues the retiree in the employees' group plan, but carves out benefits provided by Medicare to avoid duplicate coverage. In a variation on this approach, called "coordination of benefits," the plan pays what it would in the absence of Medicare, but the total payment is limited to 100 percent of the expense. Because this type of plan pays for services that Medicare does not provide, its costs are affected by changes in Medicare benefits.

The "Medicare supplement" avoids this problem by specifying exactly the benefits that will be paid by the plan. In addition, the supplement can tailor benefits to needs of the retirees. While the costs of the supplement can be easily controlled, this approach requires the design and administration of a separate plan. It also may result in a change in benefits for early retirees at age 65.

3. Issues

(A) PROTECTION FOR RETIREES

Retirees are increasingly concerned that health benefits will not be provided if an employer goes out of business or simply decides for cost containment reasons to stop providing the benefit. This is certainly a legitimate concern because, traditionally, employers have not prefunded these benefits, preferring instead to handle these obligations on a pay-as-you-go basis. The Department of Labor has estimated that, in 1983, the unfunded liability for health benefits totaled $98 billion.[56]

The LTV Corp.'s termination this year of health benefits for 78,000 retirees raised the awareness of the Congress about the tremendous unsecured promise of health benefits that has been made to retirees across the country. On July 17, 1986, the LTV Corp. filed for reorganization under chapter 11 of the Bankruptcy Code. At the same time, LTV announced that it would no longer reimburse any claims made for medical expenses on behalf of its retirees, including retirees undergoing medical procedures at the time. In response to a retaliatory strike by the Steelworkers and legislative activity by the Congress, LTV obtained permission from the bankruptcy court to reinstate health benefits for another 6 months, and the Congress began work on a series of bills to protect LTV's retirees.

At an August 7 hearing of the Senate Aging Committee on "Retiree Health Benefits: The Fair-Weather Promise," it became apparent that the task of securing retiree health benefits would be difficult if not impossible, particularly when companies enter into bankruptcy. While witnesses testified that while Congress could require vesting of health benefits at retirement, vesting would discourage employers from providing these benefits for current active workers and would possibly reduce coverage under retiree health benefits over time. In addition, while vesting would protect the health benefits of retirees of ongoing companies, it would not make a significant difference for retirees of bankrupt companies who would still lose their coverage and have only an unsecured claim for the value of the benefits. To survive bankruptcy, retiree health benefits would have to be funded and guaranteed in much the same way pension benefits are today. However, with little or no funding of retiree health extant, it is unlikely that, even with an aggressive funding strategy and generous tax benefits, retiree health benefits will be adequately funded in the foreseeable future.

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[56] U.S. Dept. of Labor. Pension and Welfare Benefits Administration. Office of Policy and Research. Employer-Sponsored Retiree Health Insurance. Washington, May 1986.

Retirees are finding some measure of protection in the Federal courts for their promised health benefits, and employers are increasingly being forced to recognize what had been, until recently, an informal obligation as a real legal and financial liability. In *Eardman* v. *Bethlehem Steel Corp.*,[57] 16,000 nonunion retirees objected to changes in their medical plans, instituted by Bethlehem Steel to contain costs. A U.S. district court, reviewing the terms of these plans, held that where the employer did not clearly retain the right to reduce or cancel retiree benefits, these benefits could not be reduced. Bethlehem appealed and, in a recent settlement, agreed to provide a permanent health program for the retirees combining the features of the original and modified medical plans.

A Tennessee case, *Musto* v. *American General Corp.*,[58] went even farther than *Bethlehem Steel*, which had implied that employers were free to modify benefits for retirees if they had clearly communicated before retirement that they reserved the right to do so. *Musto* prohibits modification by the employer regardless of what he has told his employees or retirees. Instead, the *Musto* case holds that employer health benefits "vest" upon retirement and are thereafter unchangeable regardless of the reservation clauses employers have incorporated in plan documents.

While some hail the *Musto* decision as a farreaching development in the protection of retirees' rights, others question whether it's line of reasoning will do more harm than good. The Washington Business Group on Health [WBGH] has raised the concern that a prohibition against any change in retiree health plans would prevent employers from adopting plan modifications which would help to contain escalating health care costs and increase the quality of care provided. The WBGH has warned that depriving employers of the ability to modify plans in any way will have the effect of "locking in" plans which are outmoded and wasteful, and will impose the entire burden of cost containment on future retirees.

The lower court decision in *Musto* has been overshadowed by the circuit court decision in another 6th circuit case: *Hansen* v. *White*

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[57] 607 F. Supp. 196 (1984).

[58] 615 F. Supp. 1483 (1985).

Farm Equipment Co.[59] In the *White Farm* case, the company canceled retiree medical coverage when it filed for chapter 11 reorganization. A U.S. district court reversed a bankruptcy court decision and held that the company had to continue coverage because retirees had a vested right to their health benefits at retirement and the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear.[60] On appeal, the 6th circuit reversed the district court opinion, ruling that although retirees do have contractual rights in postemployment benefits, they are not "automatically" vested upon retirement but subject to the terms of the contract.[61] The court held that only Congress, not the Federal courts, has the power to declare retiree medical benefits vested. The case was remanded to the bankruptcy court for a determination as to whether the information conveyed to the retirees clearly and expressly reserved the right of the company to terminate benefits.

The 6th circuit decision in *White Farm* directly contradicts the *Musto* ruling by a lower court in the same circuit of vested benefits under Federal common law.

(B) FUNDING OF RETIREE BENEFIT PLANS

As employers face increasing pressure to actually deliver the health benefits they have promised their retirees, they are becoming more worried that they are not financially prepared to bear these burdens and that they may need to consider some kind of prefunding mechanism. This realization is occurring because of several factors. First, the growing cost of medical care, and employers' interest in containing these costs for employees, has led employers to recognize the vast amount of resources that will be needed to provide health benefits to retirees in the future. This is particularly a problem for employers involved in older industries which have a high ratio of retirees to active employees.

Employers are also afraid that the Federal Government, in its efforts to contain costs under Medicare, will make programmatic changes which result in shifting the responsibility for more of these costs to employers, particularly when the Government sees that employers are now being liable by the courts for the delivery of health benefits they have promised.

A third factor pressuring employers is the growing recognition in the outside world that these are current liabilities of an employer which affect his net worth. A new accounting standard, recently adopted by the Financial Accounting Standards Board (FASB), requires employers to include—at least in a footnote on their annual balance sheet—a statement about how, or whether, they prefund their health benefits plans. FASB is expected within the next 2 years to adopt another standard which will require employers to show their health benefit plan as a liability on their balance sheet. This should have the effect of focusing attention on such benefits and on how, or whether, employers plan to fund them. Being required to reveal this debt on a balance sheet or annual report has potentially farreaching and worrisome implications for employers; it could make employers appear to be carrying a heavy financial debt and could put employers in a difficult position vis-a-vis applying for loans or engaging in mergers.

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[59] 23 Bankruptcy Reporter 85 (1982).

[60] 42 Bankruptcy Reporter 1005 (1984).

[61] ***Hansen* v. *White Motor*,** 788 F.2d 1186 (6th Cir. 1986).

The three factors discussed above have led employers to reconsider the desirability of prefunding retiree health benefit plans. Relatively few employers now prefund these benefits and, to date, there is no consensus as to whether prefunding is desirable. Some employers feel that their obligation to provide these benefits is now legally unavoidable and, therefore, it is wise to prefund. Others have not yet accepted the inevitability of these obligations and continue to object to prefunding.

Prefunding will remain undesirable until tax incentives are available offering favorable treatment to employers for funds set aside to pay for future health benefits—similar to the favorable tax treatment which pension contributions receive. Yet, before the Federal Government will provide favorable tax treatment for these amounts, it must feel that some guarantees exist that these amounts will be used exclusively for retiree health benefits—in other words, that a clear liability exists necessitating prefunding and the deferred taxation this entails.

Without some minimum standards guaranteeing that certain categories of retirees would be eligible for certain minimum benefits, determinable in real actuarial fashion, the Government has been unwilling to provide a tax mechanism for funding these benefits. In fact, as of January 1, 1986, one mechanism for prefunding has been removed from the tax code. Prior to the passage of the Deficit Reduction Amendments of 1984 [DEFRA], employers were able to establish VEBA's, or "voluntary employee benefit associations," into which they could set aside unlimited funds to provide for retiree health benefits. In order to receive a tax deduction for these funds, the employer only had to certify that the funds would, in fact, be used to pay for benefits.

DEFRA changed this by placing a cap on the amount of funds that could be set aside for tax purposes. Employers are now limited to setting aside no more than the total of their current expenditures for a particular benefit, plus 75 percent of that amount to account for future uncertainties. This 75-percent limit, according to benefit consultants, is far below the amounts needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care.

The Treasury Department took the position that, although the VEBA mechanism was not widely used, it had to be redrawn to avoid potential abuse. The Department stated that unlimited deductions were not appropriate for "contributions" which faced no requirements as to reporting or disclosure or limitations on total funding. This change has put the burden on employers to justify the need for a tax-favored funding mechanism for retiree health benefits. Senator Heinz chaired a Finance Subcommittee hearing to examine the issue of retiree health benefits, and to air the arguments for and against prefunding with tax incentives, but there is no consensus at this point as to what the appropriate legislative response should be. A study by the Labor Department on the issue was released in May 1986 and Congress is still awaiting a study by the Treasury Department which is overdue.

4. LEGISLATION

Legislation in 1986 was enacted exclusively in response to LTV's termination of their retiree health plan as they entered chapter 11. Three separate provisions securing benefits in bankruptcy were enacted as amendments to various pieces of legislation during the year.

The Tax Reform Act of 1986 (Public Law 99-514), contains a provision in the steel industry transition rule for the repeal of investment tax credits which permits the LTV Corp. to use its tax benefits under this section to fund the purchase of health and life insurance benefits. The intent of this section is to ensure that the bankruptcy court will permit the use of any income from the transition rule to pay for the health and life benefits of LTV retirees.

The Omnibus Budget Reconciliation Act of 1986 [OBRA] (Public Law 99-509) contains a provision extending for retirees of companies in chapter 11 bankruptcy the health insurance continuation provisions enacted earlier in the year in the Consolidated Omnibus Budget Reconciliation Act [COBRA]. Under the COBRA provision, retirees who lose their group health coverage when they retire must be offered the opportunity to continue coverage under the employer plan for a period of 18 months for the payment of premium that does not exceed 102 percent of the employer's cost. OBRA amended the COBRA provision to cover retiring or already retired employees of companies entering chapter 11 bankruptcy after July 1, 1986, and requiring that the continuation of coverage be for the life of the retiree and for 36 additional months after the death of the retiree for the retiree's surviving spouse and dependent children.

Finally, the Continuing Appropriations Resolution for Fiscal Year 1987 (Public Law 99-500) included a provision requiring that the health and life benefits being paid by companies in chapter 11 bankruptcy as of October 2, 1986, continue to be paid until May 15, 1987. The intent of this provision is to prevent LTV and other companies entering bankruptcy from terminating retiree health benefits until the Congress can return in 1987 and enact a more substantive correction to the treatment of retiree health benefits in bankruptcy.

5. PROGNOSIS

While serious legislative reform to secure or fund retiree health benefits seems unlikely in the near future, some legislation will be enacted in 1987 to protect retiree health benefits in bankruptcy. Legislation discussed at the end of 1986 and likely to be introduced in 1987 would prevent companies from unilaterally terminating retiree health and life benefits upon filing bankruptcy and would require the company to negotiate with retirees to agree on a reasonable alternative to the health plan if the company is unable to continue providing benefits. Early in 1987, there will be an effort to enact this legislation before the May 15 expiration date for the provision preventing LTV's plan termination.

In the more distant future, the anticipated FASB ruling—requiring employers to list their retiree health benefit obligations as a financial liability—should prove to be an added stimulus for discussion and debate. Further, a study due out in 1987 from the Treasury, should produce valuable information about options for funding retiree health benefits.

C. HEALTH RESEARCH AND TRAINING

1. Background

(A) NIH

Biomedical research is one of the most fundamental, yet often overlooked, ways to reduce the need for long-term care. The Federal Government's substantial investment in biomedical research for nearly four decades has resulted in America's unquestioned preeminence in science and health.

The National Institutes of Health [NIH] support extensive research on diseases of particular importance to the elderly. These include: cancer, diabetes, heart disease, stroke, organic brain disorders, and digestive diseases. The National Institute on Aging [NIA] focuses its research funds on easing or eliminating the physical, psychological, and social problems which affect the elderly population. Areas of biomedical and clinical research include studies on the genetic determinants of aging; the etiology, diagnosis, and treatment of Alzheimer's disease; osteoporosis and osteoarthritis; problems of drug use by the elderly; the impact of nutrition on aging; depression; sleep disorders; and exercise physiology in older persons.

(B) GERIATRIC TRAINING

Essential to effective, high quality, long-term care is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support was relatively unrestricted and unfocused; that is it aimed at increasing the numbers of all types of health care professionals. By the mid-1970's, this generalized effort has proven successful. Congress was able to focus on particular problem areas in the supply of health care professionals, such as geographic and specialty maldistribution. Federal finanical support was then focused on special projects: for example, more authorities were established by Congress to train primary care physicians, minority students, physician assistants, and so on.

2. Issues

(A) REAUTHORIZATION

While the agency as a whole does not require reauthorization, several programs within the NIH do need periodic reauthorization. Authority for the Cancer and Heart Institutes, the research training grants, and several smaller programs had all expired at the end of fiscal year 1983. The 98th Congress passed a bill, S. 540, that reauthorized the programs through fiscal year 1986 and made numerous changes in the NIH. Among its provisions were the creation of two new institutes (Arthritis and Nursing); the establishment of several additional new boards, commissions, and other entities; the specification of requirements concerning fetal research, animal research, and various management practices; and the recodification of NIH's statutory authority under the Public Health Service Act. The House and Senate approved the conference report in October 1984, but the President vetoed it after Congress adjourned. In his memorandum of disapproval, the President objected to the bill as unnecessary, expensive, unduly constraining on Executive branch authorities and functions, and burdensome in its managerial requirements.

In the 99th Congress, a similar bill, H.R. 2409, was introduced and vetoed. In his veto message, the President objected to the bill as an attempt by Congress to micromanage NIH and to thereby limit its ability to set the Nation's biomedical research agenda. The President's veto message characterized the bill as "imposing numerous administrative and program requirements that would interfere with the ability to carry forward our biomedical research activities in the most cost-effective manner and would misallocate scarce financial and personnel resources; establishing unneeded new organizations, which would lead to unnecessary coordination problems and administrative expenses while doing little to assist the biomedical research endeavors of NIH; and imposing a uniform set of authorities on all the research institutes, thus diminishing our administrative flexibility to respond to changing biomedical research needs."

Congress' response was a vote in both Houses which overwhelmingly reversed the veto. Senator Weicker argued that the bill did not unfairly restrain the flexibility within the NIH to guide the Nation's research agenda, but only provided a reasonable and responsible measure of guidance by the Congress in setting research priorities which are responsive to the needs of the people. He also stressed that the bill had undergone modifications to reflect the concerns expressed by the President in his veto message regarding S. 540 in 1984.

One provision of the bill which the President found particularly objectionable called for a National Center for Nursing Research. The administration found a lack of compatibility between research into patients that would be conducted by such a center and the disease-oriented biomedical research that NIH conducts. Senator Heinz and several other Members defended the creation of the center as a valuable step toward improving the quality of acute and long-term health care that will be needed by the growing older population.

(B) FUNDING FOR NIH RESEARCH GRANTS

In the past few years, funding for NIH activities has increased steadily in response to strong congressional support for biomedical research and its commitment to maintain America's preeminence in science. Funding for NIH has generally exceeded the Reagan

Administration's proposed budget levels. The administration's fiscal year 1987 budget request, for example, proposed reducing by 7 percent funding for new and competing renewal awards as well as noncompeting continuation awards.

(C) ALZHEIMER'S DISEASE

For the last several years, Congress has paid increased attention to the serious and growing problems related to Alzheimer's disease. Persons suffering from Alzheimer's disease require extensive long-term care services. This progressive, degenerative brain disorder affects an estimated 3 million persons, and cost of caring for these patients was $38 billion each year. Alzheimer's disease is the fourth leading killer in the United States, and accounts for 120,000 deaths a year.

(1) Research Into the Cause and Cure of Alzheimer's

Research into the cause and treatment of Alzheimer's disease is supported by the National Institute on Aging, National Institute of Neurological and Communicative Disorders and Strokes, the National Institute of Allergy and Infectious Disease, and the National Institute of Mental Health.

Continued funding for research into the treatment and eventual cure for Alzheimer's is essential—yet it faces the same financial threat that jeopardizes all research programs today. The Alzheimer's Disease Research Centers, established by Congress in 1984, are an important component of the concerted national effort to find a cause and cure for this disease. Since funding began in 1984, the centers have established special units to facilitate clinical and basic research, and programs in education and information transfer have been initiated. In fiscal year 1986, $9.3 million was provided for the 10 Alzheimer's centers funded through the National Institute on Aging.

(2) Research Into Ways To Assist Family Caregivers

Given the growing numbers of elderly, especially the population aged 85 and older who are at greater risk of developing this disease, the demands on long-term care services over the next decades will be staggering. Alzheimer's disease is a major predictor of institutionalization, accounting for as many as 50 percent of the elderly in nursing homes, at an average cost of $22,000 per patient per year.

Although a large number of older persons with Alzheimer's reside in the community, often with family members, both groups—the institutionalized and the noninstitutionalized—are affected by significant gaps in the long-term care system in meeting the special needs of Alzheimer's patients and their families. The tremendous national effort to find a cure and treatment for Alzheimer's was precipitated largely by a greater understanding of the financial and emotional toll of the disease on family caregivers, as well as on victims.

Alzheimer's is often classified as a mental illness and therefore receives very little coverage under Medicare. Paradoxically, Alzheimer's victims eventually need continuous care with Medicare considers not to be skilled care but custodial care and therefore does not cover. Further, Medicaid coverage is only available to victims who spend down to poverty levels. Clearly, just as the disease causes victims to be physically dependent on their families, so do Federal health programs cause victims to be financially dependent on their families. Families are spending tens of billions of dollars each year to care for these victims, and often must do so while foregoing the income of a family member who must give up his or her career to care for the victim.

At the request of Senator Heinz and several other Senators and Members of the House, a study was conducted by the Office of Technology Assessment which analyzed the reimbursement policies applied to Alzheimer's victims by Federal health programs. The OTA report made several recommendations that will serve as a basis for legislative proposals in the new Congress.

(D) GERIATRIC TRAINING AND EDUCATION

The Federal Government has yet to focus significant support on education and training in geriatric care. The House Committee on Appropriations, in its report on the fiscal year 1984 budget, requested the Department of Health and Human Services to submit a report with a plan of action for improving and expanding training in geriatrics and gerontology. In response to this, the NIA released its "Report on Education and Training in Geriatrics and Geronotology" in February 1984, assessing both the needs of the aging population and the ways in which the Federal Government could support needed education and training.

This report documents the shortage of and the projected need for personnel with training in geriatrics and gerontology. The report states that fewer than 300 medical school faculty members are involved in teaching some aspect of geriatrics today, but at least 1,350 will be needed to adequately staff medical schools in the year 2000; 8,000 geriatricians and 1,000 geropsychiatrists will be needed in 1990; the number of registered nurses in nursing homes and extended care facilities will have to double from 77,000 in 1980 to 150,000 in 1990; and the number of community health nurses with special training in gerontology and geriatric nursing will have to double, from 53,000 in 1980 to 106,000 in 1990. Similar increases will be needed in geriatric nurse faculty, geriatric dentistry faculty, geriatric social workers, social work faculty, social gerontologists and gerontological aides, and others.

Current resources to provide education and training in geriatrics and gerontology are very limited. The NIA report estimates that only about 1 percent of expenditures for training and research in the health field is concerned specifically with aging and the aged. Overall obligations for Department of Health and Human Services training programs in geriatrics and gerontology amounted to approximately $40 million in 1986.

3. LEGISLATION

(A) HEALTH RESEARCH EXTENSION ACT OF 1985

Passage of H.R. 2409, the "Health Research Extension Act of 1985," extending the statutory authorization of the National Institutes of Health and National Research Institutes, brought several substantive changes to the organization of NIH that should facilitate research beneficial to the health status of the elderly. First, the act establishes a new National Institute of Arthritis and Musculoskeletal and Skin Diseases. It is estimated that arthritis and other musculoskeletal diseases affect over 37 million Americans and that more than $1 billion is spent each year on unproven remedies and quackery. The National Institute on Arthritis and Metabolic Diseases, established in 1950, has become a multifocused institute grouping together 10 disparate research programs. The creation of this new institute will allow a focused national effort on research into the prevention, diagnosis, treatment, and eventual cure of arthritis and related debilitating diseases.

The act also created a National Center for Nursing Research with NIH to provide a focal point for promoting the growth and quality of research related to nursing and patient care, to provide leadership to expand the pool of experienced nursing researchers and to promote closer interaction with other bases of health care research.

Programs at the new center will be directed primarily toward basic and applied research related to patient care, the promotion of health, the prevention of illness, and the understanding of individual, family, and community responses to acute and chronic illness and disability.

Second, the act requires the Secretary of DHHS to conduct a study which will provide a description of the health personnel needed to meet the health needs of the elderly for the next four decades. The study, to be presented to Congress by March 1, 1987, is to include recommendations for specific numbers of personnel that will be needed, including primary care physicians, psychiatrists, and other physician specialists, as well as other nonphysician health personnel. The requirement of the study is evidence of the growing recognition of the need to develop leadership cadres of teachers and researchers in geriatrics. The study should prove to be a valuable guide in developing legislative and policy recommendations to assure the training of an adequate supply of health personnel to meet the expected health care and needs of the elderly.

(B) NIH APPROPRIATIONS

The budget proposed by the President for fiscal year 1987 would have reduced research funded through the NIH to a total of 18,000 research project grants. Within this total, 5,140 would have been new awards and 12,860 continuations. Further, the administration proposed a decrease in NIH funding of $293 million less than the 1986 appropriation.

Congress' intent to continue support for biomedical research is evident in the continuing appropriation for fiscal year 1987 which provides funding for approximately 6,300 new and competing grants through NIH, an increase from the compromise level reached for 1985. The largest budget in the history of the NIH will be available for fiscal year 1987, $6.18 billion.

(C) ALZHEIMER'S DISEASE BILLS

Late in the second session of the 99th Congress, action was taken to fund community-based care for Alzheimer's victims through the Medicare Program. This new demonstration program is described in a summary of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), in this chapter.

At a hearing before the House Select Committee on Aging on May 14, 1985, entitled "Caring for Our Nation's Alzheimer's Victims," witnesses documented the failure of Medicare and Medicaid to adequately provide for the health and mental health care needs of the victims of Alzheimer's desease. In response, the participants in the Labor-Health Services fiscal year 1986 appropriations act conference suggested that HCFA institute studies on the improvement of Medicare and Medicaid eligibility and benefits with respect to Alzheimer's disease and related disorders. The act also included a $2 million appropriation for the creation of a national Alzheimer's disease registry, which would become the repository of the State-of-the-art knowledge about the diagnosis and treatment of Alzheimer's.

Several bills on the subject of Alzheimer's were introduced in the 99th Congress, but none were enacted. Representative Roybal introduced H.R. 2280, the "Comprehensive Alzheimer's Assistance, Research, and Education Act [CARE] of 1985," to deal not only with research but also patient and family services as well. Senator Pressler, joined by Senator Heinz, introduced a companion bill in the Senate. The bill proposes: a national Alzheimer's disease education network to provide information and assistance to health care providers and to victims' families; model State programs to encourage the development and coordination of services for victims and families, allowing up to 25 percent of the funds to be used to provide respite care services; support for Medicare and Medicaid projects to explore alternative health delivery and adjustments for nursing home reimbursements; and expansion of the number of specialized Alzheimer's disease research centers. Several other bills were introduced to provide tax credits to taxpayers who provide care for Alzheimer's victims, but none were enacted.

The House Appropriations Committee, in its report accompanying the fiscal year 1986 Labor-HHS appropriations bill, directed the DHHS Secretary's Task Force and Alzheimer's Disease to submit a report on Alzheimer's to the committee prior to the hearings on the fiscal year 1987 budget. That report is to describe how the various States cover Alzheimer's patients under their Medicaid Programs, paying particular attention to the problems faced by families in gaining eligibility; the development of innovative methods of caring for patients suffering from Alzheimer's disease and other dementing disorders within the nursing home setting; and alternatives to nursing home care that exist for these patients. This report has yet to be provided by the administration.

(D) GERIATRIC RESEARCH EDUCATION AND TRAINING

In order to address the lack of funding and coordination for geriatrics and gerontology, Senator Heinz has proposed several bills to appropriately train doctors to care for older Americans. Chairman Heinz and Senator Glenn introduced S. 1100, the "Geriatric Research Education and Training Act of 1985." Senator Heinz and Senator Kennedy introduced S. 2670, the "Ambulatory Training Act of 1986" and S. 2608, the "Geriatric Physicians Graduate Medical Education Act of 1986".

The Geriatric Research Education and Training Act of 1985 [GREAT] would authorize more than a doubling of funds over a 3-year period for geriatric education and training. The bill was proposed as a cost-saver in that increased geriatric education would result, not in more doctors, but rather in more appropriately trained doctors; it would not increase the total number of providers being trained, but rather would redirect their training to better prepare them to effectively and efficiently treat elderly patients. The bill has not yet been enacted, but it has served to sensitize Congress to the importance of supporting appropriate medical education. For example, later moves to reform Medicare contributions to the costs of graduate medical education were tailored to continue support for geriatric training at Senator Heinz's urging. Further, the conferees for H.R. 2409, the "Health Research Extension Act of 1985," agreed that "there has been inadequate attention paid to the need to train doctors and other health professionals to deal with . . . the health needs of the elderly." Therefore, as noted previously, they ordered the Secretary of DHHS to report to the Congress by March 1, 1987, with recommendations for the specific numbers and types of health personnel that will be needed to meet the health needs of the elderly for the next four decades, and to include legislative and other policy recommendations necessary to assure the training of an adequate supply of health personnel.

The Geriatric Physicians Graduate Medical Education Act of 1986 proposed an increase in funds allocated for training medical faculty in geriatrics. Further, this legislation encourages practicing physicians to return to the classroom for specialized training in the care of the elderly. Portions of S. 2489 were included in an omnibus health bill (Public Law 99-610) at the close of the 99th Congress. Beginning in 1988, increased funding for geriatric training within title VII of the Public Health Act will be available.

The Ambulatory Care Training Act, S. 2670, would authorize the use of graduate medical education funds presently available through Medicare to encourage training in settings outside acute care hospitals. Recent changes in the length of hospital stay have increased the role of ambulatory settings including nursing homes, clinics, and health maintenance organizations, in the medical care delivery system. S. 2670 proposed to bring Medicare funding of medical education in line with these changes. The Congress did not act on S. 2670 in 1986.

Chapter 8

LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private medigap insurance. Many elderly persons and their families pay the full costs out-of-pocket, making long-term care the single greatest threat to the financial security of older Americans.

Neither significant public nor private improvements in long-term care financing and delivery are on the immediate horizon. The reluctance to implement new long-term care initiatives can be attributed to three factors. First, the 6 million older Americans who need long-term care are a relatively new phenomenon—with no tradition to help mobilize congressional interest or action. Second, the enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform. Third, no current consensus exists on the best way to finance long-term care.

But the need for improvement in long-term care has grown more pressing. During the past 2 years, a series of hearings held by the Senate Special Committee on Aging disclosed a new and troublesome trend. It was determined through these hearings that Medicare beneficiaries are being discharged from hospitals "sicker and quicker," in large part because of the implementation of the Medicare prospective payment system [PPS]. More importantly, these sicker beneficiaries are being discharged into the already strained long-term and subacute care system. Therefore, many Medicare beneficiaries are not able to obtain the continued care they often need after hospital discharge.

Federal initiatives to provide long-term care are lacking. The theory behind implementation of PPS was that patient length of stay in costly hospitals would be decreased and that greater amounts of less costly continued care would be provided in the home or nursing home setting. This substitution is occurring, but the Health Care Financing Administration [HCFA] under the Department of Health and Human Services [DHHS] appears to be limiting reimbursement for those substitute services. In the face of enormous Federal deficits, few observers expect the Congress to tackle a major new long-term care initiative in the near term.

In early January 1987, Secretary of DHHS Dr. Otis Bowen testified before the Senate and House Aging Committees on his proposal for catastrophic illness coverage. The President, in his 1986

State of the Union Address, specifically charged DHHS with the task of drafting such a proposal.

Secretary Bowen's proposal would use an expanded Medicare part B to cover catastrophic hospital costs for the elderly and a combination of State and private initiatives to meet these acute care costs for the rest of the population. Various tax incentives, such as Individual Medical Accounts [IMA's] were the primary financing vehicles for long-term care needs.

The biggest weakness in the Bowen proposal is the limited set of options the Secretary offers for long term care. His recommendations for tax credits, such as the IMA's, by emphasizing institutional settings, invite care that is more expensive, perhaps inappropriate, and even less desirable than care in a home or community. These long-term care incentives, further, rely too heavily on solutions that are unlikely to help lower-income and even middle-income individuals and families.

Bowen's proposal also would not really expand coverage beyond current services under Medicare for the aged. For example, prescription drugs would remain an out-of-pocket expense. Providing catastrophic hospital coverage through an additional part B premium would not ensure access to coverage for those low-income individuals who do not get Medicaid and who cannot afford the added cost.

Secretary Bowen's proposal, despite its limitations, successfully focused congressional attention on the issue of catastrophic health care costs and will serve as a backboard off which to bounce more comprehensive solutions.

Private initiatives alone are unlikely to solve more than a small portion of the problem. The experience of private insurers to date has been disappointing. Long-term care insurance policies have not caught on with the American public, especially among those young enough to purchase insurance when it is more affordable. Employers, too, have shown a reluctance to offer a new long-term care benefit, though there are now available several group plans offered by insurance companies.

A. BACKGROUND

1. Types of Long-Term Care

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (e.g., nursing homes) to noninstitutional settings (e.g., adult day care centers and a person's own home). Community-based long-term care typically encourages a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education.

Long-term care services incorporate the needs of two different types of patient. Some long-term care services meet the health care needs of subacute patients who have recently been discharged from a hospital, while other patients with chronic conditions require care in a nursing home or other facility for an extended period of time.

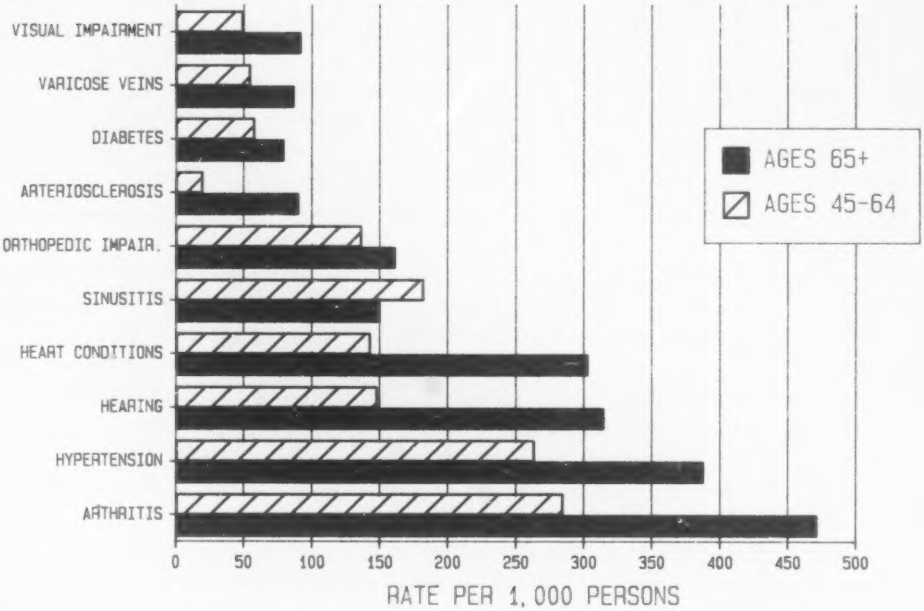
Access to long-term care by discharged patients is a growing problem. In hearings before the Senate Special Committee on Aging, it has been established that while the prospective payment system is causing Medicare patients to be discharged sooner and sicker from hospitals, too often, these patients do not have access to needed home health and skilled nursing care. While the problem of access to needed post-hospital care is not new, it has worsened under the incentives of the prospective payment system.

The second category of long-term care patients is the more traditional patient: Those with functional disabilities, mental disorders, and other nonacute ailments that require maintenance or custodial care over long periods of time. Long-term care for those patients is characterized by extended medical, personal, social, and psychological care at home or in institutions. The need for long-term care coincides not with particular medical diagnoses, but rather with chronic physical or mental disabilities that impair functioning.

Chronic conditions are problems of aging and, as such, are responsible for a large portion of the Nation's health expenditures. More than four out of five persons 65 and over have at least one chronic condition and multiple conditions are commonplace in the elderly. However, most older persons are able to live independently in spite of these conditions. According to the 1982 data from the National Long-Term Care Survey, about 19 percent of older persons living in the community report that they can no longer carry on normal activities because of chronic conditions. In the 1982 population of persons over age 65, the leading chronic conditions were arthritis, hypertensive disease, hearing impairments and heart conditions. (See Chart 8-1).

CHART 8-1

PREVALENCE OF TOP TEN CHRONIC CONDITIONS: 1983



SOURCE: National Center for Health Statistics, Division of Health Interview Statistics

A significantly higher proportion of persons age 65 and older than persons under age 65 are limited in their abilities to perform normal daily activities due to a chronic condition. As shown in chart 8-2, it is those over age 75 who are most hindered by chronic conditions.

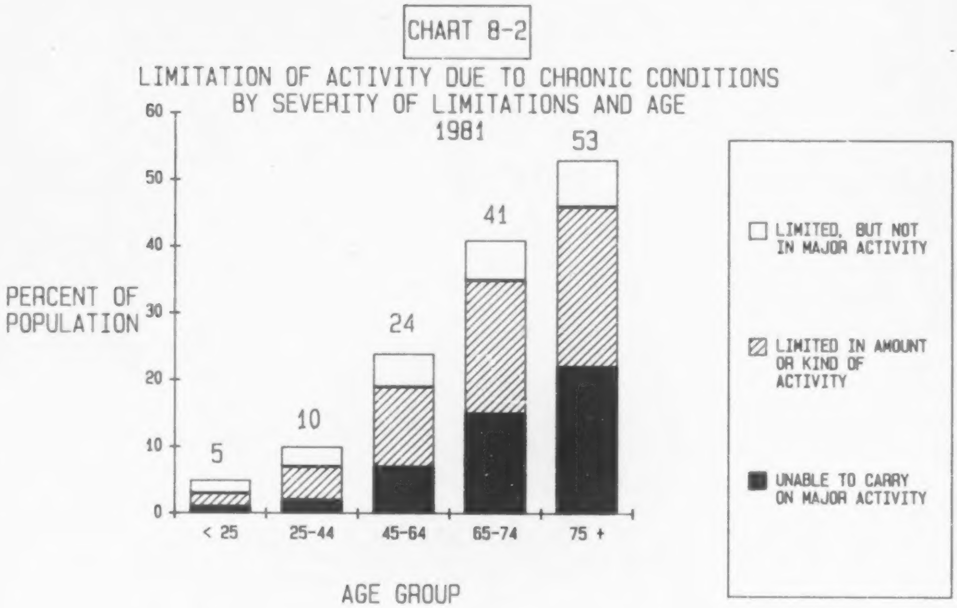


CHART 8-2

LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS BY SEVERITY OF LIMITATIONS AND AGE 1981

SOURCE: National Center for Health Statistics, 1981 Health Interview Survey, unpublished

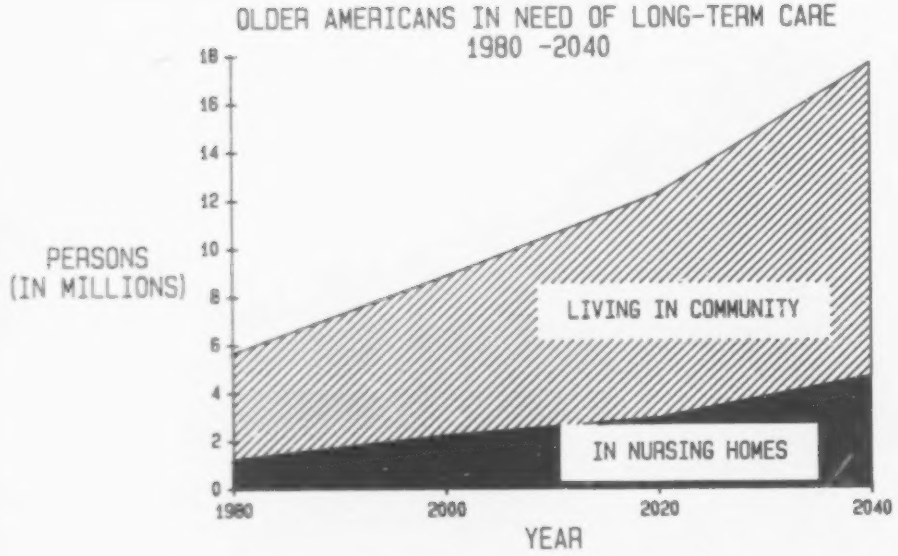
2. Numbers of People Receiving Long-Term Care

(A) NURSING HOME CARE

In 1985, nearly 12 million elderly citizens had some degree of limitation of daily activity due to chronic conditions, but only an estimated 1.5 million older Americans were confined to nursing homes. Between 1985 and 2000, this population is expected to increase by 47 percent, to 2.2 million people, and then double to 4.4 million between the years 2000 and 2040.

Chronic illness can prevent individuals from functioning independently without assistance. For those over 65 with a chronic condition in 1985, an estimated 5.2 million persons required some assistance in performing the activities of daily living to maintain independence. This figure is expected to reach 7.2 million by the turn of the century, 10.1 million by the year 2020, and 14.4 million by 2050. Other groups requiring some measure of long-term care include the mentally retarded, the developmentally disabled, and the adult chronically mentally ill.

CHART 8-3



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

A large proportion of noninstitutionalized older Americans may be in need of more extensive long-term care than they receive in the community. According to the National Center for Health Statistics, 2.1 million of the noninstitutionalized elderly need help in one or more basic physical activities (getting in and out of bed, dressing, eating, bathing, using the toilet) and 2.4 million elderly need the help of another person in carrying out home management activities. In addition, approximately 425,000 of the noninstitutionalized elderly usually stay in bed all or most of the time because of a chronic health problem.[1]

For some of these very dependent people, the nonavailability of beds is a factor preventing their placement in nursing homes. While there are no firm nationwide estimates of the potential needed supply of nursing home beds, experts agree that there are serious shortages of beds throughout the country, with estimates ranging into the hundreds of thousands. Certain localities report a short supply of beds as measured by the numbers of long-term care patients backlogged in acute care hospitals awaiting discharge to a nursing home.

Although only 5 percent of all older Americans are likely to be in a nursing home at any given time, that likelihood increases with age. In 1985, an estimated 2 out of every 100 persons in the 65 to 74 age group, 7 out of 100 persons in the 75 to 84 age group and about 16 out of 100 persons in the 85-plus age group were in a nursing home on any given day.[2] With rapid growth in the oldest age group will come increased demands for nursing home care.

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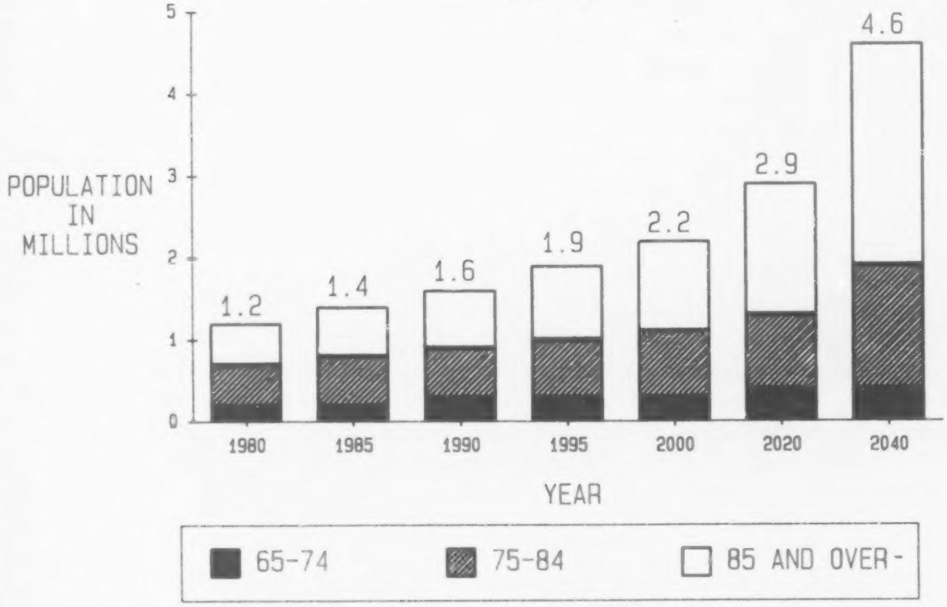
[1] National Center for Health Statistics, 1977 National Nursing Home Survey.

CHART 8-4

NURSING HOME POPULATION PROJECTIONS
PERSONS 65 YEARS AND OLDER BY AGE GROUP
1980-2040



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

(B) HOME HEALTH CARE

For every person 65 years of age and over residing in a nursing home there are nearly four times as many living in the community requiring some form of long-term care. The 1982 National Long-Term Care Survey estimated that approximately 4.6 million noninstitutionalized elderly Americans—about 19 percent of the over 65 population—had limitations in activities in daily living [ADL's] and instrumental activities of daily living [IADL's]. Limitations in ADL's reflect dependence in certain basic self-care functions such as bathing, dressing, and eating, and limitations in IADL's refer to levels of disability in the performance of a daily routine, including shopping, cooking, and cleaning. The 1982 survey found that approximately 850,000 elderly individuals were residing in the community with severe limitations in activities of daily living.

Of the 4.6 million disabled elderly, almost 70 percent relied exclusively on nonpaid sources of home and community health care. Almost 1 million received at least some paid care and only 240,000 used paid care only. Of those who received both paid and unpaid care, nearly 41 percent were sole payors for this care, Medicare paid for community care for 8.4 percent of this group and Medicaid paid for about 6 percent. Private insurance pays only about 1 percent of the Nation's long-term care bill.

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[2] Ibid.

3. COVERAGE AND FINANCING

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, inkind transfers, or the provisions of goods and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing homes.

In 1985, total expenditures for nursing home care were $35.3 billion. Between 1965 and 1983, the total cost of nursing home care increased 7 percent above the rate of inflation, and is projected to continue rising an average of 4.7 percent above inflation each year between 1983 and 1990. In constant dollars, total nursing home expenditures will increase by more than 50 percent between 1980 and 1990. Forty-seven percent of nursing home expenditures was financed by Federal, State, and local governments.

By far the largest portion of public expenditures for nursing home care is financed by the Medicaid Program for the poor and medically indigent. In 1986, Federal and State Medicaid expenditures for nursing home care amounted to $16.6 billion—representing approximately 42 percent of total national spending, 89 percent of public spending for nursing home care, and 44 percent of total Medicaid spending for all covered health care services.

By way of contrast, the Medicare Program accounts for only a small portion of the Nation's expenditures for nursing home care. Medicare's expenditures amounted to $585 million and represented less than 2 percent of national spending and 3.5 percent of public spending for nursing home care in 1985.[3]

(A) MEDICAID

(1) Coverage

The Medicaid Program, which provides medical assistance for certain low income persons, excludes most older Americans. Medicaid has nonetheless become the primary source of public funds for nursing home care. Approximately 89 percent of all public expenditures for nursing home care is paid by Medicaid and 48 percent of all nursing home residents are Medicaid beneficiaries. Each State administers its own program and, subject to Federal guidelines, determines the Medicaid income eligibility standard

State Medicaid Programs are required by Federal law to cover the categorically needy, that is, all persons receiving assistance under the Aid to Families with Dependent Children [AFDC] Program and most people receiving assistance under the Supplemental Security Income [SSI] Program. States may also cover persons who would be eligible for cash assistance, except when they are residents in medical institutions, such as skilled nursing facilities [SNF's] or intermediate care facilities [ICF's].

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[3] HCFA, Office of the Actuary.

In addition, States may, at their discretion, cover the medically needy, that is, persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for medical care. These State variations mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

To control costs and to provide a range of community-based services to the Medicaid-eligible population, many States have applied to the Department of Health and Human Services [DHHS] for section 2176 Medicaid waivers. In 1981, congress established these waivers, giving DHHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a SNF or ICF. Services covered under the 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration's support for the 2176 waiver program, as is discussed later in this chapter.

(2) Expenditures

Federal Medicaid expenditures for nursing home care in 1986 were approximately $17.6 billion, of which $5.5 billion was spent on SNF's, $6.9 billion for ICF's and $5.2 billion for ICF for the mentally retarded.[4] Medicaid financed 89 percent of Federal spending and 43 percent of total nursing home expenditures. Even though the elderly and disabled constitute only 28 percent of Medicaid recipients, they account for 74 percent of Medicaid expenditures. More striking, nursing home residents comprise only 7 percent of all Medicaid recipients, but account for 48 percent of all costs.[5]

Medicaid expenditures have been growing rapidly since 1972, but the fastest growth has been in long-term care (nursing home) expenditures. (See chart 8-5.) Increasing numbers of elderly nursing home residents accounts for a portion of this growth, but the cost of nursing home care has grown at twice the rate of beneficiary growth. For example, the number of ICF residents (non MR) grew by 3.9 percent between fiscal year 1984 and 1985, while the cost per resident grew by 7.7 percent, nearly twice the rate.[6] The growth in costs for SNF benefits is even more dramatic: The number of recipients actually declined by 2.2 percent during this period while costs per resident rose by 7.7 percent.

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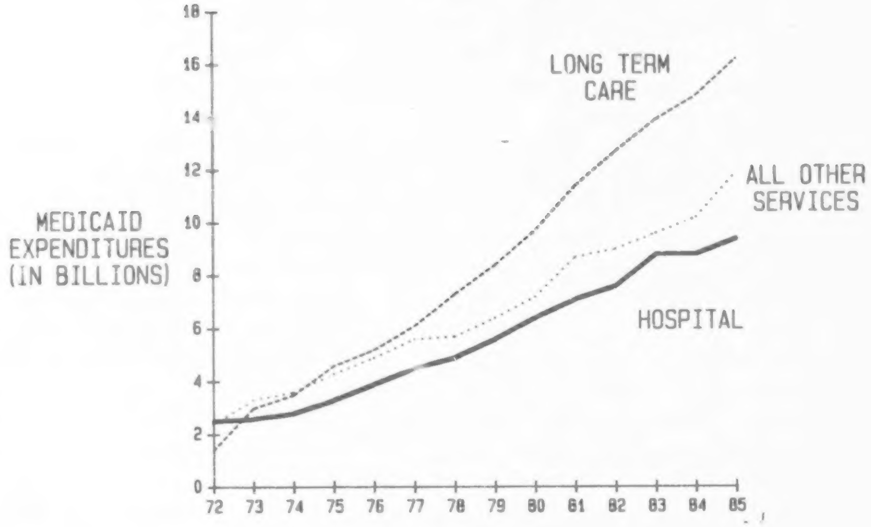
[4] Health Care Financing Administration, unpublished data based on November 1986 data.

[5] Ibid.

[6] Congressional Budget Office, 1987.

CHART 8-5

GROWTH IN MEDICAID EXPENDITURES
1972 - 1985



SOURCE: U.S. Health Care Financing Administration, 2082 Medical Care Statistical Report, December 30, 1986

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1985, Federal Medicaid expenditures for home health care were $1.1 billion, accounting for less than 3 percent of total Medicaid spending. In 1982, the last year in which these data were collected, home health benefits constituted more than 1 percent of total Medicaid expenditures in only nine States. One State, New York, spent 78 percent of all Medicaid home health dollars.[7]

Because Medicaid expenditures consume between 10 to 15 percent of State budgets, many States are seeking to control the growth of their nursing home population and their obligated Medicaid expenditures. As many as 26 States made changes in nursing home reimbursement policies to reduce costs in 1981 and 1982, with several States adopting a preadmission screening process and limits for the number of beds reserved for Medicaid beneficiaries.

(B) MEDICARE

(1) Coverage

The Medicare Program, which insures almost 98 percent of all older Americans without regard to income or assets, does not cover either long term or custodial care. Primarily, it provides acute care coverage for those age 65 and older, particularly hospital and surgical care and accompanying periods of recovery. For example, Medicare covers up to 100 days of SNF services following a hospital stay of at least 3 consecutive days. Further, in order to receive reimbursement under Medicare, the patient must be in need of skilled nursing care on a daily basis for treatment related to a condition for which he or she was hospitalized. The SNF benefit is subject to a daily patient copayment after the 20th day of care. In 1986, the copayment was $61.50 per day, rising to $65 in 1987. The program pays for neither intermediate care facility services nor custodial care in a nursing home.

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[7] Health Care Financing Administration, Medicaid Statistics Branch, 1986.

Even though Medicare coverage of home health care is only for short periods of care and only for treatment of an acute care condition or for post-acute care, the Medicare home health benefit is the fastest growing component of the Medicare Program.

Home health services covered under Medicare include the following:

—part time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;
—physical, occupational, or speech therapy;
—medical social services provided under the direction of a physician;
—medical supplies and equipment (other than drugs and medicines);
—medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and
—part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must be in need of part time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, e.g., deductibles or coinsurance, for covered home care.

In addition to these SNF and home health care benefits, Medicare covers a range of long-term care services, and especially home care services, for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, therapy services, medical social services, home health aide services, physician services, counseling, and short term inpatient care. For fiscal year 1985, Medicare paid $15 million in benefit payments for hospice care.

There is no statutory limit on the number of home health visits covered under Medicare; but according to HCFA, home health care should generally be available for just a few weeks. HCFA's recent attempts to restrict use of the home health benefit have been the subject of congressional hearings and legislation, discussed in more detail later in this chapter.

While coverage of long-term care services is restrictive and limited, older Americans apparently believe that Medicare's coverage includes basic long-term care services. In fact, a recent survey by the American Association of Retired Persons [AARP] found that of older persons surveyed, fully 79 percent believed that Medicare would pay for part, if not the entire cost, of their nursing home care.

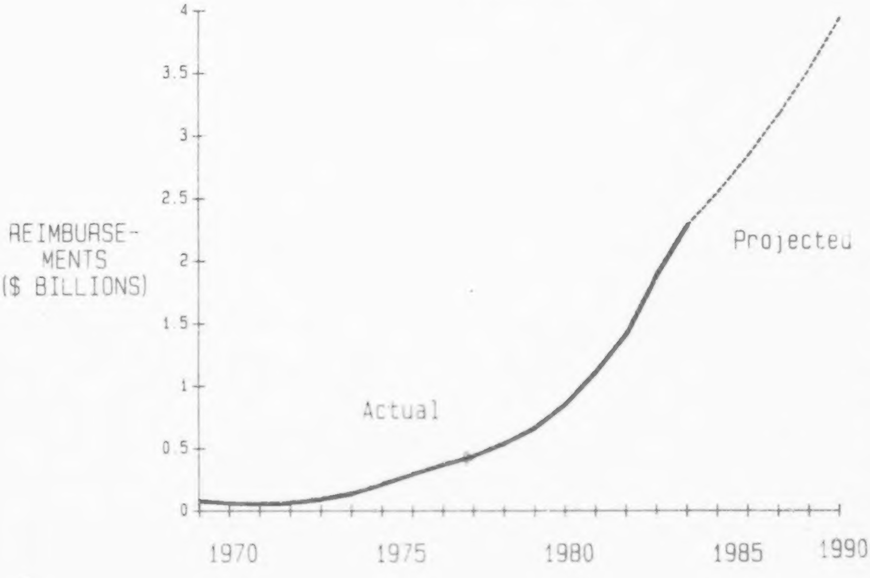
(2) Expenditures

Medicare expenditures for long-term care generally have been small. In 1985, Medicare's contribution to SNF care was only $590 million, less than 2 percent of total public and private spending for nursing home care and less than 1 percent of total Medicare spending.[8]

Medicare payments for home health care comprise less than 3.3 percent of total program outlays. For calendar year 1986, total reimbursements for Medicare home health services were projected to be $2.5 billion. Chart 8-6 indicates, however, that Medicare's home health benefit expenditures are the fastest growing component of **the Medicare Program.**

CHART 8-6

MEDICARE HOME HEALTH REIMBURSEMENTS
1969 - 1990



SOURCE: HCFA/Bureau of Data Management and Statistics

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[8] O'Sullivan, Jennifer, Medicare: Fiscal year 1987 Budget, Congressional Research Service, Education and Public Welfare Division, August 18, 1986, updated, p. 6.

(C) TITLE XX

(1) Coverage

Title XX of the Social Security Act authorized reimbursement to States for social services, now distributed via the Social Services Block Grant [SSBG]. Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are not appropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated. Data concerning the extent to which title XX now supports long-term care is therefore unavailable.

(2) Expenditures

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of title XX funds—States are provided relative freedom to spend Federal social service block grant funds on State-identified service needs. Legislation in the 98th Congress permanently increased the per year expenditure ceiling to $2.7 billion, effective in fiscal year 1984. In fiscal years 1985 and 1986 the appropriation level was again $2.7 billion and remains at that level for 1987.

(D) THE OLDER AMERICANS ACT

(1) Coverage

The Older Americans Act [OAA] carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities, and social services. While the OAA thus funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each OAA area agency on aging is required to spend a portion of its supportive services allotment on home care services.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount under Medicare and Medicaid. The OAA services, however, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid. In some cases, OAA funds may be used to service persons whose Medicare and Medicaid benefits have become exhausted or who are ineligible for Medicaid. Approximately 2.4

million in-home service visits were provided under the OAA in 1984.

(2) Expenditures

Unlike the title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of title III funds for supportive services, for congregate nutrition services and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies on aging some flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Total fiscal year 1987 appropriations for title III are $692 million. Fifty percent of the funds, or $348 million, were for congregate nutrition services, and 39 percent, or $270 million, were for supportive services and senior centers. Only about 11 percent of the Federal appropriations, or $74 million, was devoted to home-delivered nutrition services.

(E) PRIVATE INSURANCE

(1) Medigap

Seventy-two percent of older Americans purchase supplemental medical insurance, or medigap policies.[9] About half of this supplemental coverage is provided on a group basis—mainly through retirees' former employers—and about half is purchased individually. These policies are typically designed to supplement Medicare's coverage of acute care costs, not long-term care costs.

To illustrate, some medigap policies cover the daily copayment from the 20th to the 100th day of an approved stay in a Medicare SNF. Others provide coverage for skilled care, as defined by Medicare, in a certified facility for stays of 100 to 356 days, or longer. The value of medigap coverage for long-term care, however, is very limited. These policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs.

(2) Long-term Care Insurance Policies

Currently, only about 1 percent of the Nation's long-term care expenditures is paid for by private insurance. A 1986 survey by the Health Insurance Association of America found that 12 companies offered individual indemnity life insurance and that there were 130,000 policyholders with an average age of 75. These policies typically offer indemnity benefits for 3 years of care in a licensed nursing care facility. Ten of the 12 policies continue coverage after the need for skilled nursing care is fulfilled and the long-term care needs become custodial in nature. Fifteen additional companies are developing new products.

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[9] Congressional Budget Office Tabulations of Survey of Income and Program Participation, April 1984 (as cited in Statement of Nancy M. Gordon before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, 3/26/86).

There are several common features of the types of benefits offered by these companies. First, they all offer indemnity benefits ranging from $10 to $50 per day. Offering an indemnity benefit, rather than paying the total costs of nursing home services, limits the insurer's liability and thereby reduces the risk of the policy to the insurer.

Second, all policies are offered with either a deductible or a reduced benefit for some initial period of time. Those in the Health Insurance Association of America survey, for example, offered a choice of either 20 or 100 days during which a person must be in a nursing home before payments begin. This ensures that the more frequent short stays do not increase the cost of insuring the less frequent, but more expensive, long stays. In effect, these policies protect against catastrophic costs and are more like casualty insurance than traditional health insurance: Only individuals with extended stays are fully eligible for many plan benefits.

Third, all policies are to some extent oriented to a stay in a SNF or care in a facility with a full-time nurse. By excluding home care benefits, it is easier for the insurer to define the insurable event and thereby, to limit the insurer's liability.

These factors reduce the cost of the policies, but may also reduce both their desirability to many persons and their effectiveness in reducing overall costs. These characteristics of private long-term care insurance may also turn out to be an obstacle to efforts that are underway to stimulate a shift from institutional care to home care.

(F) OUT-OF-POCKET COSTS

While the cost of long-term care represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

The vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 and 80 percent of those elderly persons living in the community who need long-term care receive all of the care they need from family and friends. The remaining 20 to 30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.[10] Between 60 and 95 percent of home care is given by family and friends.

This home care is rendered to 1.2 million disabled elderly persons by 2.2 million friends and relatives. In 75 percent of the cases, care is given via a live-in arrangement. Ninety percent of the caregivers are low- or middle-income.[11]

Home care is generally a less expensive option for the elderly, but about 14 percent have out-of-pocket costs from home care that range from $360 to $1,680 per year, depending on the level of disability.[12] These out-of-pocket costs are only for home care, they do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

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[10] Callahan et al., 1980; Christianson and Stephens, 1984; Liu et al., 1986; as cited in Stone, Cafferata, Sangl, Caregivers of the Frail Elderly; A National Profile.

[11] (Stone, Cafferata, Sangl, Caregivers of the Frail Elderly: A National Profile.)

[12] 1982 National Long-Term Care Survey.

The cost of community-based care pales in comparison to the cost of nursing home care. The price of a year in a nursing home ranges from $12,000 to $50,000; the cost at even the lower end of this range is beyond the resources of most older Americans. Thus, many elderly people must spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Currently, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicaid. A recent study released by the House Select Committee on Aging shows that this spend down occurs on the average within 13 weeks after admission for the single older American.

B. ISSUES

1. Home Health Care Denials

In 1983, Medicare changed the method for paying hospitals from a pay-as-you-go system to the prospective payment system [PPS] based on pre-determined rates for specific diagnosis-related groups [DRG's]. Since then, Medicare patients have been sent home from the hospital after shorter stays, in greater need of follow-up health care, than ever before. At the same time, the Health Care Financing Administration, which operates the Medicare Program, has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. As a result, more Medicare beneficaries need home health care at a time when less care is available.

A July 28, 1986, public hearing of the Senate Aging Committee, held in Philadelphia, found that increasing numbers of seriously ill Medicare patients are in need of home health care, but that even larger numbers are being denied access to care. Since implementation of the Medicare Prospective Payment System, hospital discharges to home health have increased by 37 percent. During the same period, the rate of growth in home health services has slowed—Medicare-covered visits rose an average of 19 percent from 1980 to 1983, but only 8 percent in 1984, when the demand was greatest.

The committee's investigation found home health care denials have nearly tripled since the first quarter of 1983 when PPS was initiated—during the first quarter of 1985, Medicare denied 47,855 claims. In Pennsylvania alone, 2,332 Medicare beneficaries were denied home health care coverage in the 8-month period between September 1985 and April 1986.

Government policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers, result in reduced access to home health care for older Americans, witnesses told the committee. HCFA uses unwritten and unpublished guidelines to limit the Medicare home health benefit. The Health Care Financing Administration has repeatedly tried to eliminate the "waiver of liability" which gives home health agencies critical flexibility in interpreting Medicare rules and regulations so they aren't forced to deny access in cases where eligibility is in question.

One home health agency, for example, received a denial of home health care benefits for only one patient since the inception of Medicare in 1966—until 25 patients were denied benefits in a recent 6-month period between September 1985 and April 1986.

HCFA has placed limits on home health providers' abilities to appeal decisions denying Medicare beneficiaries home health care and has made it very difficult for Medicare beneficiaries to appeal decisions themselves. HCFA has limited providers' right to appeal denials. For example, technical denials (such as denials based on the definition of homebound) are not paid under the waiver of liability and only a beneficiary can submit a technical denial for reconsideration. Moreover, once a denial is paid under the waiver of liability it cannot be appealed.

HCFA no longer allows Medicare beneficiaries to designate home health providers as their representatives in appealing coverage denials. Many Medicare patients live alone and are too sick to make their way through the bureaucratic jungle to appeal these denials. As a result, Medicare beneficiaries have no realistic protection under the Medicare Program without access to a suitable representative.

At the July hearing, the Aging Committee put forth the following recommendations:

(1) Home health providers should be allowed to represent Medicare beneficiaries in home health appeals.

(2) Fiscal intermediaries should be held accountable in part for incorrect and inappropriate decisions which result in denials of care to Medicare beneficiaries. This can be accomplished by including reversals of fiscal intermediary decisions in performance evaluations for contract renewals.

(3) The waiver of liability should be made a permanent part of the Medicare law and must cover all vague coverage criteria, including that a Medicare beneficiary must be a homebound and must receive only intermittent care.

(4) HCFA should give home health providers clear instructions regarding all rules and regulations affecting the home health benefit and should do everything possible to make the administration of the Medicare home health benefit more consistent and uniform.

(5) HCFA should be brought under the Administrative Procedures Act to ensure public notice of all instructions and transmittals which would have the effect of changing the nature and extent of the Medicare benefit.

(6) HCFA should establish demonstration programs for prior authorization for Medicare home health claims.

(7) Congress should enact S. 778, the Home Care Protection Act, which would ensure beneficiaries adequate home care by clarifying the law to state that the Medicare intermittent home health benefit can include care provided on a daily basis for up to 60 days, with physician certification of need.

A report from the General Accounting Office [GAO], "The Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs," requested by Senator Heinz, was delivered to the committee in December 1986. The blue book report showed that hundreds of thousands of chronically ill older Americans are not receiving the home health assistance they need under the Medicare Program.

GAO attributed much of the problem of inappropriate denials, as well as program abuse, to "vague" coverage criteria. Despite a 1981 recommendation by GAO, the Health Care Financing Administration has not clarified coverage criteria relating to frequency of care, homebound status, or provided enough training on how to interpret existing criteria, the report says. It goes on to say that "inconsistent interpretations of the criteria can result in unequal access to home health services."

The GAO report identifies internal "weaknesses" in administering the home health services and estimates these weaknesses cost the taxpayer almost $600 million in improper payments in fiscal 1984. The report goes on to say that savings realized through improved program controls, such as those recommended in 1981, could be used to provide benefits to those not now served. Recommendations from the GAO include further studies to determine the effect of stronger, clearer guidelines and internal controls over the home health program on the number of Medicare beneficiaries with unmet home care needs.

2. NURSING HOME QUALITY OF CARE

Thousands of old and sick citizens live in nursing homes which fail to provide care adequate to meet even their most basic health and safety needs. The problem of poor quality nursing home care has been exposed and examined many times and in great detail over a period of years, most recently through a 2-year investigation conducted by the Senate Special Committee on Aging. Yet, the remedies always have seemed to be just out of reach.

Unfortunately, many barriers prevent good quality nursing home care from reaching America's oldest and most vulnerable citizens. Federal and State governments, to begin with, have not fulfilled their responsibility to ensure that nursing home residents are provided proper care. While this Nation has come a long way in improving the physical facilities in nursing homes, thousands of patients still suffer from poor nutrition, inadequate nursing care, and general neglect that many people hoped had been corrected long ago by State and Federal reforms.

Existing Federal and State enforcement policies are so seriously lacking that, in 1984, over one-third of the Nation's skilled nursing facilities failed to comply with even the most essential health, safety, and quality standards of care. Nearly 1,000 of these homes failed to meet these basic standards year after year, providing clear evidence that no effective penalties exist to sanction nursing homes that provide poor quality care.

Second, payment for nursing home care, especially under the Medicaid Program, has been inadequate in many areas of the country for years. To some degree, Federal and State governments have been asking for high-quality care at bargain basement prices. Some nursing homes respond to low reimbursements by cutting corners, including hiring untrained or inadequately trained staff.

Today, regulations provide for two types of nursing homes—skilled nursing facilities [SNF's] and intermediate care facilities [ICF's]—and require much less stringent standards for the latter than for the former. In reality, very little difference exists between the types of patients who reside in those facilities. Some have argued that all participating nursing homes should meet a single set of high standards now applied only to SNF's.

At present, the only Federal sanction available is to require that a substandard nursing home be closed and patients moved to other settings. Given the shortage—or absence—of empty beds in most parts of the country, it is understandable why this penalty is rarely used. Legislation introduced by Senators Heinz and Glenn (S. 2604) would mandate surprise, random inspections and create a set of "intermediate" sanctions to be used against nursing homes that violate good quality care standards. These sanctions include civil fines, restrictions on further admission of patients to the facility, and placing substandard facilities under receivership. These intermediate measures would allow patients to continue receiving care while the Federal and State governments monitor required improvements.

To remedy the problem of inadequate payments, this bill proposes the implementation of a case-mix reimbursement system for Medicare and Medicaid nursing homes. Case-mix reimbursement would allow the Federal and State governments to more closely tie patient reimbursement to the level of patient care.

3. MEDICAID COVERAGE FOR IMPOVERISHED AGED

Medicaid was created as the health care safety net for this Nation's poor. On balance, it has served them very well. There are, however, 2.2 million elderly persons whose incomes are a few dollars too high to allow them to qualify for Medicaid under traditional income tests, but far too low to allow them to afford the health care they need. Medicaid currently covers only 36 percent of America's aged poor.

There are only two ways to qualify for Medicaid. Categorical eligibility is linked to eligibility for SSI, while "medically needy" eligibility is determined by spending down through medical costs to 133 percent of the AFDC level. Unfortunately, in both cases the individual's income must be far below poverty. For example, the SSI income eligibility limit is $111 less than poverty ($336) per month for a single person and $199 less than poverty ($504) per month for a couple.

Medicaid coverage for this population group is especially important since the elderly and disabled poor have large health care needs. Death rates among the elderly poor are 50 percent higher than for other Medicare beneficiaries. Despite their greater health needs, they receive 35 percent fewer physician visits, use 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital.

4. PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nearly 800,000 Medicaid nursing home residents depend on their "personal needs allowance" [PNA] each month to cover a wide range of expenses not paid for by Medicaid. The personal needs allowance amounts to $25 a month or 82 cents per day. The PNA has not been increased—even to adjust for inflation—since Congress first authorized payment in 1972. As a result, the PNA is worth less than $10 in 1972 dollars. Thus, all recipients of Social Security and SSI benefits have received COLA's to their benefits since 1974, except the frailest and most vulnerable—Medicaid nursing home residents.

For impoverished nursing home residents, this minimal allotment represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eye glasses, clothing, laundry, newspapers, and phone calls. In 15 States, more than half of the $25 must be spent on laundry alone.

In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, preventing them from tending to personal needs.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the cost and guarantee the nursing home resident a bed to come back to.

Concern that the PNA is far too low and below what Congress had originally intended led several Senators to prepare legislation to provide a modest increase in the PNA. The bill, prepared by Senator Heinz and supported by Senators Kennedy, Durenberger, Moynihan, and Glenn, was budget neutral (it actually saved $6 million over 3 years), using savings from a Medicaid second surgical opinion program for certain elective surgeries.

This amendment would not have increased the PNA to a level that would enable nursing home residents to live in luxury, nor would it even have restored all of the purchasing power that the PNA has lost by not being adjusted for inflation in the last 14 years. Rather, this amendment would have increased the PNA by only $5 a month in fiscal year 1988, and allow for a further increase and cost-of-living adjustment beginning in fiscal year 1990.

The second half of the bill—the second surgical opinion program—would provide savings to Medicaid recipients, and State and Federal Governments—not only in terms of dollars, but in human lives as well. Under this provision, Medicaid patients would be required to obtain a second medical opinion before undergoing certain elective surgical procedures, enabling them to protect themselves against unnecessary surgery. The purpose of the second opinion is to inform a patient whether an independent medical evaluation confirms the diagnosis and the necessity of surgery, and to offer for consideration any alternative treatment.

CBO estimated that the second opinion proposal would save the Federal Government $20 million in the first year and $25 million in every year after that. Similar savings will result to State governments.

Congress, in the first session of the 99th Congress, moved to institute a mandatory second surgical opinion program under the Medicare benefit in the Budget Reconciliation Act. In 1986, the administration proposed a Medicaid second opinion program. By including this provision in the 1986 budget reconciliation bill, the Congress could have claimed the savings toward the deficit reduction goal and used part of the savings to increase the meager allotment given to the poorest of the poor—Medicaid nursing home residents.

The costs of increasing the personal needs allowance from its current level of $25 a month to $30 on October 1, 1987, would have been more than offset by the savings available through the Medicaid second surgical opinion program. Pairing these two provisions would result in $20 million fiscal year 1987 savings to the Federal Government and savings to most State Medicaid budgets.

This amendment had the support of the Villers Advocacy Associates, AARP, the Leadership Council on Aging, the Save Our Social Security Coalition, the National Senior Citizens Law Center, the National Council of Senior Citizens, and other key health advocacy groups.

The proposal to increase the personal needs allowance was not offered as an amendment to the reconciliation bill because of time constraints. A version of the mandatory Medicaid second surgical opinion program found its way into law through administrative policy changes.

5. End Stage Renal Disease

More than half of this Nation's 1,300 end stage renal disease dialysis clinics reuse dialysis devices that are designed and labeled by manufacturers for "single-use only."

Dialysis is a critical life-sustaining treatment required to remove toxins, salt, and water that accumulate in the blood of a person whose kidneys have ceased to function because of end stage renal disease [ESRD]. Treatment requires the patient to be connected three times a week for 3 to 4 hours to a dialysis machine which filters out these life-threatening toxins. The only alternative to dialysis is kidney transplantation. Medicare funds 80 percent of dialysis costs for all ESRD patients.

Life-saving dialysis has been practiced for more than 20 years and today is provided by Medicare at a cost of over $1.5 billion to more than 78,000 patients. More than half (48,000) of the patients are 55 and older; over 26 percent (27,000) are 65 and older; and 34 percent of new patients annually are 65 and older.

A growing practice in dialysis clinics in recent years has been the reuse of certain dialysis devices that are labeled by manufacturers for "single-use only." Reused most often are the plastic cylindrical dialyzer blood filter and the plastic blood lines through which the patient's blood flows to and from the dialyzer. Other equipment subjected to reuse includes the transducer filter and dialyzer caps.

All dialysis clinics are reimbursed by Medicare at the same rate, regardless of whether or not they reuse disposables. Hospital based clinics receive $131 per dialysis treatment, and freestanding facilities are reimbursed $127 per treatment. A new disposable dialyzer costs about $10 and is the most expensive disposable device used in dialysis. Blood lines cost about $3. Reprocessing of these two disposables saves about one-half to one-third the cost of buying new ones each time they are reused. Figures generated by the Office of Technology Assessment indicated that reuse of the dialyzers alone may result in excess profits of $80 million or more each year.

Some dialysis clinicians believe that reuse of the dialyzer combats "first-use syndrome," an allergic reaction to a new dialyzer. The FDA determined that only about 3.3 such reactions per 1,000 patients occurred over a 2-year period. The FDA also found, however, that in most of these cases, the dialysis facility failed to follow the manufacturer's instructions for properly preparing the dialyzer for patient use in order to avoid any negative reaction to the new dialyzer. Clinicians also have found that certain types of membranes used in dialyzers may cause allergic reactions, a problem often solved by switching patients to a dialyzer with a different type of membrane.

More than 60 percent of the dialysis clinics are reprocessing and reusing disposable devices as many as 20 or 30 times by flushing out and "disinfecting" them with a solution most often consisting of formaldehyde and water. Formaldehyde is known to cause cancer, liver damage, and destruction of red blood cells. Research has shown that formaldehyde can cause the formation of antibodies in the blood that may encourage rejection of a kidney transplant. In addition, formaldehyde reportedly causes allergic reactions, and central nervous system and reproductive disorders.

Patients who are treated with reused disposable dialysis devices also face the risk of their devices—and therefore their blood—being contaminated with virulent strains of bacteria if reused equipment is not properly sterilized.

The Senate Aging Committee uncovered these facts through a 4-month, in-depth investigation into the issues of reuse of disposable kidney dialysis devices. During this investigation, interviews were conducted with scientists, clinicians, and patients involved in hemodialysis study, practice, and treatment. Interviews were also conducted with key personnel at the Food and Drug Administration, the Health Care Financing Administration, and the National Institutes of Health. Published research papers were reviewed, as well as thousands of internal records from these three Federal agencies.

On March 6, 1986, the committee held a hearing on reuse of disposable dialysis devices to examine its findings and receive testimony from renal physicians and dialysis patients, as well as from HCFA and the FDA.

Four major problems associated with reusing disposable dialysis devices were brought to light through the investigation and hearing: (1) Proper clinical trials have yet to be conducted to conclusively determine the health effects of reusing disposable devices, (2) the FDA and HCFA have failed to develop standards to ensure safe reuse procedures, (3) dialysis patients who receive dialysis treatment with reused equipment usually are not informed of the potential risks associated with reuse, and (4) dialysis patients who know the potential risks and request not to be treated with recycled equipment are often denied any choice in the matter and are, in effect, forced to submit to treatment with reused equipment.

Many issues were raised in connection with these problems, and many solutions were sought. First was the issue that administration proposed rate reductions would encourage further reuse of dialysis devices. Second, patient advocates wanted ESRD patients to be given the ability to accept or refuse dialysis with reused devices. Third, others wanted no further reuse of dialysis devices or equipment until clinical trials to examine the safety and efficacy, including patient morbidity and mortality, of reuse were conducted.

In 1983, the Health Care Financing Administration moved to reduce reimbursement rates by $12 per treatment in an effort to encourage greater use of home dialysis. Since then, the use of home dialysis decreased and the incidence of reuse—a money-saving procedure for ESRD facilities—skyrocketed from 18 to 60 percent. Those who opposed further rate reductions were concerned that reducing the rates would seriously jeopardize lives and safety of the 80,000 Medicare dialysis patients in this country. For this reason, Senator Heinz pushed the Congress to act in reconciliation conference to keep Medicare ESRD rates at current levels, which would not have the effect of increasing or encouraging reuse.

C. LEGISLATION

1. Home Health

The Omnibus Reconciliation Act of 1986 (Public Law 99-509) included several of the committee's recommendations regarding improvements in home health care. For example, one provision provides beneficiaries with the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria. Also, the waiver of liability for home health agencies was extended and will continue to be in effect until 12 months after the 10 new regional fiscal intermediaries begin operation—a date which is not yet known. Cost limits for home health agencies will be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, effective with cost-reporting periods beginning on or after July 1, 1986. These latter two provisions are designed to grant home health agencies greater flexibility so they can better serve the Medicare population.

2. Nursing Home Quality Reforms

On June 26, 1986, Senators Heinz and Glenn introduced major legislation that would comprehensively address the many quality of care problems plaguing nursing homes in this country. This legislation, S. 2604, the Nursing Home Quality Reform Act, was based on the findings of the committee's hearing and investigation into the current status of quality of care in nursing homes and on recommendations made by the Institute of Medicine on improving nursing home quality of care.

The purpose of this bill was to first, improve the quality of care and quality of life in nursing homes; and second, to create a strong, effective enforcement system to ensure that substandard care is met with appropriate and swift penalties.

Major portions of the Heinz/Glenn nursing home reform package were included in H.R. 1868, the "Medicare and Medicaid Patient and Program Protection Act," which gained approval of the Senate Finance Committee, but did not see floor action in the 99th Congress. Specifically, the provisions included in the larger bill would:

—Require training and competency testing for nursing home nurse aides.

—Extend the rights of residents in skilled facilities to those in intermediate care facilities.

—Strengthen the enforcement sanctions against homes that discriminate against Medicaid patients.

—Require nursing homes to maintain clinical records on all residents and provide accurate physical assessments for each.

—Require that inspections be unannounced and conducted on a random time schedule.

—Make quality of care the focus of inspection and require public disclosure of all inspection reports.

—Require States to train nursing home inspectors and make each inspection team multidisciplinary.

—Require the Secretary of Health and Human Services to develop a proposal for case mix reimbursement for nursing homes by January 1, 1988.

This issue traditionally evokes strong emotional responses from the various interested parties. From the senior advocates point of view, nursing home residents have long suffered abuse of every sort at the hands of nursing home operators and nursing homes are little more than forgotten warehouses of the old and the infirmed. To the nursing home industry, Medicare and especially Medicaid payments for nursing home residents are far below the actual cost of care and nursing homes are providing the best quality care possible at those bargain basement prices. This issue is sure to be considered in the 100th Congress and has the support and interest of Congressmen Dingell and Waxman, the chairs of the House Energy and Commerce Committee and Subcommittee on Health and the Environment, respectively.

3. Medicaid Coverage for Aged Poor

While the 99th Congress was very concerned with cutting programs and reducing the deficit, it still found a way to mend some of the holes in the Medicaid safety net. To address the problem of the aged who fall below the poverty line but do not qualify for Medicaid, S. 2492, the Low-Income Elderly Protection Amendment of 1986, was introduced in the Senate by Senators Heinz, Bradley, and Burdick. A companion bill, H.R. 4882, was introduced in the House by Representatives Waxman and Schumer. Both bills would separate Medicaid eligibility from eligibility for AFDC and SSI, giving the States the option to provide Medicaid coverage—with matching Federal payments—if a senior citizen or a disabled person's income is at or below the Federal poverty rate.

The effect of the bill would be to provide Medicaid health care and prescription drug coverage to low income elderly and the disabled, and to cover their Medicare premiums, deductibles, and coinsurance payments.

The costs of providing this health care coverage to this targeted group was relatively low. The Congressional Budget Office estimated that this legislation would cost the Federal Government only $38 million in the first year and only $79 million per year when fully implemented. This legislation goes hand in hand with legislation introduced earlier in the 99th Congress by Senators Chiles and Durenberger. The Chiles and Durenberger bills would allow States to provide Medicaid coverage to pregnant women and children below the Federal poverty line. S. 2492 complements these bills by giving each State the option of providing Medicaid coverage to elderly and disabled poor only if coverage is also provided to pregnant women and children below the poverty line in that State.

Both initiatives, to expand Medicaid coverage for low-income seniors and for pregnant women and children, were approved as part of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).

4. Reuse of Kidney Dialysis Equipment

Congress this year also took action to protect patients who have end stage renal disease and are treated with reused dialysis devices that are meant to be used only once. The Senate reconciliation package, as put forth by the Senate Finance Committee, would have cut ESRD reimbursement rates by $1 per treatment, compared with a $5.50 per treatment reduction advocated by the House. The two Houses of Congress compromised through reconciliation conference to reach a $2 per treatment reduction in ESRD facility Medicare payment rates.

To address a second issue of patient choice, Senator Heinz introduced the ESRD Patient Rights Act of 1986. This bill was supported by Senator Glenn. This legislation was to provide dialysis patients with information on the potential risks and benefits of reuse, give patients the right to choose or reject dialysis treatment with recycled dialysis equipment, and ensure that patients cannot be turned away from treatment if they decide not to accept treatment with recycled equipment.

This bill would have resulted in no additional costs to either the Federal Government or dialysis providers. Neither would this legislation add a new and burdensome paperwork requirement to the ESRD program. Currently, facilities are required to receive the patient's written consent before administering treatment in the ESRD program. These written consent forms are kept on file and reviewed by the appropriate State survey agencies in determining whether facilities meet the conditions of Medicare participation. Unfortunately, this legislation was not accepted by the Senate.

To address the third problem of clinical trials, the Omnibus Budget Reconciliation Act (Public Law 99-509) requires that the Secretary impose standards and conditions for safe and effective dialyzer reuse and reprocessing, enforceable as a condition of Medicare participation effective October 1, 1987. Beginning January 1, 1988, no reuse of blood lines, transducers, caps, and other accessories shall be allowed in Medicare-certified ESRD facilities until and unless standards and conditions for safe reuse and reprocessing of these devices and equipment are imposed as a condition of participation.

D. PROGNOSIS

Congress this year may well deal with the problem of uninsured long-term care catastrophic illnesses. While any such action will most likely focus on private efforts, or private/public combinations, for financing coverage expansion, any steps toward providing older Americans and others with ways to pay for nursing home care other than today's reliance on spend down will be welcome. Congress also will almost certainly take up the issue of nursing home quality of care reform to provide solutions to the persistent problems of substandard nursing home care.

Congress also will take up the issues of nursing home prospective payment, nursing home case mix reimbursement, home health care payment and coverage, and welfare reform.

The administration is likely to propose legislation to dramatically restructure the way Medicaid health benefits are provided through the States, by offering States financial incentives to use risk and cost sharing arrangements in the form of health maintenance organizations. Some will probably be receptive to the idea, given the savings that may be available, but the issues of access to health care and the quality of care provided should be given serious consideration. The House may be less enthusiastic about this proposal, however, especially since Congressman Waxman has traditionally been very skeptical of the fairness and quality of care that HMO's and HIO's have to offer Medicaid populations.

Chapter 9

HOUSING PROGRAMS

OVERVIEW

Housing and shelter needs of the elderly have been a primary concern in the area of aging social policy for a number of years, and during the last two decades the Federal Government has substantially increased its response to this concern. The question today is: Has this response reached its peak?

HUD program activity has been on a substantial downward slope since fiscal year 1981. The largest decline has been in the assisted housing category, down from $25 billion to $10.8 billion—nearly 60 percent—between fiscal year 1981 and fiscal year 1985. Because approved funding of these programs is scheduled to be spent over a long period of time—20, 30, or even 40 years—cuts in budget authority are slow to result in reductions in outlays or actual spending. Thus, in spite of substantial reductions in budget authority, outlays on assisted housing programs increased from $5.75 billion in fiscal year 1981 to an estimated $10.6 billion in fiscal year 1986. The number of households receiving aid increased from about 3.2 million in 1981 to 4.2 million in 1986. These increases, however, are attributable to funding made prior to the Reagan Administration as well as to the shortening of contract terms. This result in the appropriation of requested budget authority being postponed to future years, therefore increasing the number of households presently assisted by a given quotient of authority.

During 1986, the administration and Congress did little to advance the cause of providing housing to the Nation's elderly, handicapped, and poor. In fact, the administration attempted through its fiscal year 1986 budget proposal to place a 2-year moratorium on virtually all new construction, and to drastically limit other modernizing and operating expenses. Congress, on the other hand, had little success changing the course of current housing programs.

In 1986, no housing authorization law was passed by Congress. A continuing resolution (Public Law 99-500) appropriates $601.3 million in contract authority and $7.8 billion in budget authority for housing programs assisted under the Department of Housing and Urban Development [HUD] in fiscal year 1987.

The need for elderly housing continues to increase. A growing elderly population is one factor. Current demographic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75.[1] From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent, and those headed by persons over 75 will increase 52 percent. In 1995, 21.4 million households will be headed by Americans over 65.

In addition, there is a growing need for special living arrangements and support services for older persons. An increasing number of frail elderly—those over 75 years of age with mild to moderate impairments in their activities of daily living—are aging in place in Federal housing projects and in private residences. This stark fact raises serious questions on ways to best provide a supportive environment where social, physical, and emotional needs are met without jeopardizing the independence of older Americans.

Rapidly escalating housing costs have contributed to the need for Federal programs. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses. Housing costs for the elderly are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans. The problem is particularly acute for renters, who pay a far larger share of their incomes for housing than homeowners. Recent data indicate, for example, that an elderly woman living alone spends nearly 50 percent of her income on housing. Some 2.3 million elderly households spend over 35 percent of their incomes on housing.

The majority of the elderly have equity in their homes that could help in meeting their housing needs. Three out of every four elderly persons own their own homes; 80 percent of them, mortgage free. These are often elderly suburban homeowners with low incomes and few significant liquid assets. These factors have contributed to the growing interest in innovative housing arrangements, such as home equity conversion plans, and in strategies for allowing the "overhoused" elderly homeowner to take advantage of more appropriate, maintenance-free housing through such alternatives as life-care communities.

A. FEDERAL HOUSING PROGRAMS

1. General Background

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. One approach has been to provide housing directly through new construction programs and rental assistance payments which are aimed at providing adequate and affordable housing for those who could not otherwise afford it. A second and more costly approach has been to provide tax incentives for house construction and home ownership through deduction of mortgage interest and property tax payments from individual gross income and through a variety of tax provisions favoring real estate transactions.

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[1] U.S. Bureau of Census Population Survey, unpublished data.

Heightened concern with old age housing issues had its origins in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for legislation to be enacted that would eventually target the elderly as beneficiaries for such housing assistance.

Although low-income public housing, created under the Housing Act of 1937, was not initially intended to provide special assistance for the elderly, it began to evolve into one of the principal forms of Federal assistance for low-income older persons in the late 1950's. Prior to 1956, only 10 percent of all the units were occupied by persons 65 years and older. Between 1956 and 1959, however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing unit occupied by the elderly increased to 19 percent in 1964 and to 46 percent in 1984. In addition, 1959 saw the enactment of the section 202 program, the first housing program specifically designed for the elderly.

In the mid-1970's, Congress expanded Federal housing assistance to the elderly significantly. The section 202 elderly housing program was reinstated after being phased out in the late 1960's and the section 8 housing assistance program was enacted which, although not specifically targeted to the elderly, has become one of the two major sources of assisted housing units occupied by those 65 years of age and over. Today, section 8 provides approximately 800,000 units of assisted housing for the elderly. Another major source, public housing, provides roughly 650,000 units for elderly families. As of December 1984, there were approximately 2,438 section 202 projects nationwide, with 142,120 occupied housing units. Of these, 730 projects with about 16,900 units occupied by the physically or mentally handicapped.

(A) SECTION 202

The section 202 program is the primary Federal financing vehicle for constructing subsidized rental housing for elderly persons. Under the section 202 program, the Federal Government makes direct loans to private, nonprofit sponsors for use in developing section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped. Since the program's authorization in 1959, close to 150,000 units have been constructed.

The original section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year permanent loans at 3 percent interest to nonprofit and limited dividend sponsors of housing for low-and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised section 202 program, authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. The 202 loan rate was fixed at 9¼ percent in 1983, in response to rising interest rates, and it has remained fixed at this rate since.

The original section 202 program was successful. Only one project was foreclosed in a 10-year period. The program served basically middle-income rather than low-income elderly during this time. Since the revised program is used in conjunction with the section 8 program (HUD's major vehicle for the provisions of housing to low-income households), it serves a wider range of elderly households.

Under the revised section 202 program, funds are allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels. In 1983, there were approximately 4.7 million elderly rental households representing about 26 percent of all elderly headed households in the United States.

For fiscal year 1987, the 1986 continuing resolution (Public Law 99-500) appropriates $592.6 million of direct loan obligations to be made under the section 202 program. This amount is intended to provide funding for the construction of approximately 12,000 new section 202 units—approximately the same number funded in the 2 previous fiscal years.

A large percentage of new construction of housing over the past 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

A review of the HUD section 202 elderly housing program completed by GAO in December 1985 provided some basic information on how the program is actually being utilized. Nearly all of the program beneficiaries were single. Beneficiaries on average were 73 years old, were white, had lived in their unit/project for about 2.5 years, and had an annual income of about $6,600. Most (82 percent) had very low incomes—below 50 percent of the median income (adjusted for household size) for the areas in which they lived.[1]

Most beneficiaries lived in a one-bedroom unit that rented on average for $480 per month and contributed about $146 toward this rent. The balance of $334 was paid by the Government through section 8 rental assistance payments.

GAO found that in the survey sample the housing needs of minority elderly are not being met by the 202 program. Minority elderly are on average poorer than white elderly yet most projects have few if any minorities. Of the 142 projects sampled, (1) 42 percent of the projects, which accounted for about 33 percent of program beneficiaries, had no minority tenants, and (2) 70 percent of the projects, with 68 percent of the tenants, had 5 percent or fewer minority tenants. Sixty percent of the minorities in the sample were housed in 13, or 9 percent of the projects sampled. At each of the 13 projects, more than 50 percent of the tenants were minorities.

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[1] The analysis conducted by GAO is based on a review of HUD records for 179 projects at 10 HUD field offices, visits to 47 of these projects, and data on 802 section 202 projects, obtained from HUD's Computer Underwriting and Processing System. The study was limited to projects primarily serving the elderly.

(B) PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.2 million units housing more than 3.5 million people. In fiscal year 1986, the program cost the Federal Government more than $5.4 billion for operating subsidies, construction debts, and major repairs.

The Low-Rent Public Housing Program is the oldest of those Federal program providing housing for the elderly. Over 43 percent, or approximately 514,000 units, of the Nation's more than 1.2 million public housing units are occupied by older Americans. It is a federally financed program which is operated by locally established, nonprofit public housing authorities [PHA's]. Each agency usually owns its own projects. By law, the PHA's can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Federal assistance to the public housing projects is in the form of annual contributions that are used to pay the PHA's debt service. Originally this was the only form of Federal public housing assisrance. It was assumed that tenant rents, originally set at amounts no higher than 25 percent of a tenant's net income (now raised to 30 percent), would cover project operating costs for such items as management, maintenance, and utilities. Over the past few years, tenant rents have not kept pace with increased operating expenses. Recent changes requiring greater targeting of benefits to the very low income group (50 percent of area median rather than 80 percent) also decrease rental revenues for the public housing authorities. As a result, Congress has provided additional assistance to the projects to cover these expenses. Annual operating subsidies totaled $1.2 billion in fiscal year 1986.

Much of the public housing was built three and four decades ago and is in need of major renovation. Even its staunchest supporters admit that the program has been plagued by mismanagement in some cities, often aggravated by local political interference and patronage. And, it is a system that has become home for manay chronically unemployed and underemployed people who can ill-afford to pay significantly more in rents to offset the skyrocketing cost of operations and maintenance.

About half of all the units in assisted projects were developed under and continue to be operated within the public housing program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters: By Congress about the condition of the projects and their management; by public housing authorities [PHA's] about their rising costs and the inadequate funding levels for modernization; and by the Office of Management and Budget [OMB] about ever-burgeoning outlays. Additionally, the managers of the public housing projects continue to raise their conern about the lack of congregate services for their tenants who have aged-in-place and are in need of supportive services in order to remain independent.

(C) SECTION 8

(1) Construction/Existing

The section 8 program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Under the program, HUD enters into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Payments made to owners and developers under assistance contracts are used to make up the difference between what the rental household can afford to pay for rent, and what HUD has determined to be the fair market rent for the dwelling. As of the end of fiscal year 1985, there were 2.4 million units reserved under the program, of which about 2 million are completed or, in the case of existing housing, ready for tenant certification by a public housing agency. Of those units, it was estimated by HUD that approximately 40 percent are occupied by older persons.

The concern over the Federal deficit has forced the Federal Government to reassess the cost-effectiveness of many social programs, including the new housing construction programs. Section 8 was not designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing, but was structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found that they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970's. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's [GNMA] purchase of mortgages under its special function, or by financing from State housing financing agencies or from public housing agencies, both of which obtained funds from sale of tax-exempt bonds. GNMA exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through State housing finance agencies by means of the finance adjustment factors [FAF], which in effect raised permissible rents over the fair market rent level. The relatively high subsidy cost arising from both the high rent supplement required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and the Congress. Finally, in the Housing Act of 1983, the section 8 new construction program was repealed except for that attached to the section 202 program.

While the production component of the section 8 program has been viewed as unsuccessful, the existing housing component of the section 8 program has generally been alluded to as a successful form of assistance. Under section 8 existing housing program, HUD pays the difference between 30 percent of an assisted housing tenant's income and the fair market rent standard for the jurisdiction. In fiscal year 1986, HUD paid approximately $7.4 billion in section 8 housing assistance to eligible families. This figure includes funding for the voucher program, which appears to be the administration's answer to subsidized housing in the future.

(2) Vouchers

The Housing Act of 1983 continued existing section 8 certificates but also established a section 8(o) demonstration voucher program. Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's new rental rehabilitation program, the FMHA Rental Preservation Grant Program. However, 5,000 units were allocated to a "free-standing" program to provide an opportunity to compare the operation of the voucher program with the section 8 existing certificate program. The continuing resolution (Public Law 99-500) appropriates $1.03 billion for 53,000 additional housing vouchers. Under the voucher system, also referred to originally as the modified section 8 existing housing certificate, HUD's contribution is also based on the difference between established rent payment standard for each market and 30 percent of a new tenant's income. Like fair market rents, the rent standard is set at the 45th percentile of the distribution of rents of standard quality in newly occupied units, and tenant eligibility is based on an income standard of 50 percent of area median income.

The tenant, however, will pay more or less than 30 percent of his income for rent. HUD's contribution is still based on a 30-percent-of-income contribution, but the rent standard is not necessarily the actual, or maximum, rent. Rather, the rent received by the landlord is based on whatever is negotiated between the tenant and landlord, as in the private market. Thus, if a tenant finds a unit which is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit which is more costly than the rent standard HUD uses, that tenant would have to contribute more than 30 percent of income to make up the rent payment. Another difference between the two programs is the duration of the assistance contract which is limited to 5 years under the voucher program compared to the 15-year duration of the section 8 existing housing contracts. The HUD Appropriations Act for 1985 provides $500,000 for HUD's research budget to evaluate vouchers versus 5- and 15-year section 8 contracts. This evaluation has not been completed.

(3) Rental Rehabilitation and Development

New rental rehabilitation and production programs were enacted under title I of the Housing and Urban-Rural Recovery Act of 1983 (Public Law 98-181). The programs authorize Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under section 8), greater requirements for local public and private sector investments in the projects, stricter limits on Federal per unit costs, and greater demonstration of rental housing need by local authorities. Interim regulations governing the rehabilitation portion of the program were issued on April 20, 1984, while regulations governing the production segment of the program were published on June 14, 1984.

The Rental Rehabilitation Program, authorized at a level of $300 million for fiscal years 1984 and 1985, is formula driven and allocates funds directly to selected cities with populations of 50,000 or more, urban counties, and States for distribution to smaller communities. The program is targeted to low- and moderate-income families. The first grants under the program, which totaled $14.2 million, were awarded to 76 cities and urban counties and one State in August 1984. Grantee communities will get housing vouchers or section 8 certificates to assist lower income families to remain in their unit after rehabilitation activities are completed or to relocate to other suitable housing.

According to HUD's second annual report, $144 million of commitments to guarantees had been made through June 30, 1985, and by the end of July, work was under way on 2,247 projects with 16,424 units. However, the fiscal year 1986 appropriations bill (Public Law 99-160) cut the program's annual budget from $150 million to $75 million.

The Rental Housing Development Program, authorized at a level of $200 million and $115 million for fiscal years 1984 and 1985 respectively, is run on a competitive basis and is targeted toward low- and moderate-income families as rental rehabilitation grants. Implementation of this program was delayed by the controversy over the size and composition of cities eligible to compete for grants. On June 20, 1984, HUD published in the Federal Register a list of areas designated as eligible for program assistance. On October 23, 1984, HUD announced the awarding of $288 million to 141 projects. It is estimated that these awards will assist in the construction of 14,462 units. Fiscal year 1986 appropriations were cut to $75 million.

The $150 million authorized for these two programs for fiscal year 1986 is very modest compared to the costs of section 8 new construction/substantial rehabilitation programs which they are designed to replace. The latter, for instance, were allocated more than $10 billion in new budget authority in fiscal year 1981. The continuing resolution appropriates $299.5 million for rental rehabilitation and development in fiscal year 1987. These funds can be used until the end of 1989 if funds remain available, but use of development funds is limited to localities which have very low vacancy rates (below the national average).

(D) TAX PROVISIONS

The principal tax provisions encouraging home ownership in this country are the mortgage interest and property tax deductions. The latter is probably more important to elderly owners since many have fully paid their mortgages. Under the Tax Reform Act of 1986 [TRA 86], interest on mortgages in existence prior to August 16, 1986, on a first or second home will remain fully deductible. Interest on mortgages incurred after that date, however, will be deductible only to the extent that total loan amounts equal no more than the original purchase price of the owner's current home plus the costs of home improvements. An exception is made for home loans used for qualified educational or medical expenses. However, the sum of all such equity-secured loans cannot exceed the current market value of the home. This new rule means that those who have lived in their current home for many years and now have substantial equity, may find the after-tax cost of loans secured by this equity is higher because the interest may not be deductible. The same loan limits apply to an owner's second residence.

Of particular importance to the elderly, the one time exclusion that allows a homeowner aged 55 or older to sell his home and exclude up to $125,000 of capital gains from the Federal income tax, would continue. A number of important tax subsidies having to do with the provision of rental housing are reduced or eliminated under the new Tax Act. There is a less generous depreciation schedule, limitation on the amount of rental losses that can be deducted from an investor's salary, interest, and dividend income, and the end of preferential capital gains taxation. A new 9 percent tax credit will be available each year for 10 years for new construction or the rehabilitation of existing buildings where the owner sets aside a specified percentage of units for a specified number of years for low-income renters. In addition, the use of tax-exempt bonds for multifamily rental housing is continued, with some modifications, until the end of 1988.

2. ISSUES

(A) LIMITING THE FEDERAL ROLE

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in that the Federal Government has been unwilling to treat housing assistance as an entitlement. As a result, many eligible households simply cannot find the assistance they need. Data indicates that the total of over 4 million assisted units available at the end of fiscal year 1985 are enough for, at best, 25 percent of those eligible for assistance.

According to a 1986 report of the National Low Income Housing Coalition, Federal housing efforts have fallen far short of meeting elderly housing needs. In 1984, there were 1.1 million elderly renter households with incomes below the poverty level. Only 444,000, or not quite 40 percent, of these households lived in subsidized housing. The remainder lived either in substantial housing or paid more for housing than they could afford, or both. The Coalition estimates that, at a minimum, a need for housing assistance for almost 700,000 poor elderly renters exists. In addition, there are 1.5 million elderly homeowners with incomes below the poverty level. They note that only one small Federal program—section 504, the Farmer's Home section of the Very Low Income Home Repair, Loan and Grant Program—is currently focused on meeting their needs, and this operates only in rural areas.

(1) Limits on New Construction

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget savings. The net effect of these fiscal constraints is a policy shift by the current administration toward other approaches for meeting the housing needs of older persons. The main thrusts of the administration's housing assistance policies have been to shrink the growth of the program and to seek less expensive solutions. Since 1981, it has attempted to contain the budgetary growth of housing programs by targeting assistance to those most in need, and relying almost exclusively on direct assistance to households in existing units.

The proposed administration housing budget for fiscal year 1987 would have cut fiscal year 1986 funding level by $8.6 billion—almost 50 percent. The Reagan Administration also proposed elimination of the section 8 moderate rehabilitation program and the section 202 housing program for the elderly and handicapped.

A housing authorization bill has not been sent to the President since 1983 when, responding to the administration's policies and concerns over continued high Federal budget deficits, Congress enacted the Housing Act of 1983 (Public Law 98-181). This legislation eliminated authorizations for the section 8 New Construction Substantial Rehabilitation Program, restricted new construction of public housing to 5,000 units, and limited the authority to build new units to those jurisdictions that could prove that demand and inadequate supply of usable, existing units made new constructions the only reasonable alternative.

The section 202 program narrowly escaped a similar fate. Congressional efforts and concerns, however, served to maintain the program at funding for 12,000 new units. Under the act, the section 202 program remained the only housing subsidy authorized to use the section 8 new construction funds.

The 202 program is the most visible elderly housing program, and it has had its problems and criticisms. While it has generally produced financially-viable quality housing projects for the elderly and the handicapped, it has also experienced some political controversy. These disputes stem from several problems, including the program's high costs of production, the tendency, at least of the original program, to serve primarily moderate- and middle-income elderly, and the annual cost of the program to the Federal budget because of its use of direct loans from the Federal Government at reduced interest rates.

In 1983, the Reagan Administration requested that the number of section 202 units built be reduced from 14,000 units (already down from 18,000 units in 1981) to 10,000 units. Efforts to curtail the program are contrary to what the Aging Committee's 1984 survey results demonstrate to be the demand for section 202 units.[2] There are an average of six section 202 units for evey 1,000 elderly persons in the county and less than one-fifth of a project's units become vacant annually. As a result, there are over one-quarter of a million persons (270,000) waiting to get into the 2,438 section 202 projects nationwide. Waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

In 1985, $600 million was appropriated for 12,000 units of section 202 housing. As part of the President's spending freeze to reduce the Federal deficit, his fiscal year 1986 budget proposed a 2-year moratorium on new assisted housing production. Congress, however, did not agree with this proposal and $631 million was appropriated in fiscal year 1986 for the construction of 12,000 section 202 housing units. For fiscal year 1987, $593 million has been appropriated to fund the construction of approximately 12,000 units of housing for the elderly and handicapped.

Section 202 has been the target of numerous regulatory and administrative changes, however, which are aimed at making the program more cost-effective and targeting assistance to the neediest of elderly and handicapped persons. These recent changes in program direction as well as those continuing policy issues mentioned earlier have been, and will continue to be, the focus of debate in years to come.

Other features of the 1983 housing bill reinforced action taken in 1981 to limit eligibility for rental assistance to the neediest families—those at 50 percent of median income—and to raise the rent contributions of those assited from 25 to 30 percent of adjusted income. In a compromise forced by those opposed to the rent increase, deductions to adjusted income were raised for families with minor children and for the elderly.

The housing bill of 1983 also reaffirmed the administration's interest in the use and rehabilitation of existing housing, and authorized further experimentation with the administration's housing voucher proposal. Their emphasis on using existing housing is based not only on cost considerations but also on the administration's belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met most efficiently by providing section 8 certificates or, preferably, vouchers to eligible families for use in existing rental housing.

The shift from new construction to existing section 8 was made for a number of reasons. For the first time, substantial use could be made of the existing housing stock, with a consequent reduction in per unit subsidy costs from those incurred in new construction. It was hoped that use of the existing stock would provide recipients of aid with a greater choice of location and housing type, since they would not be restricted to specific, designated developments. A higher income subsidy provided to owners would encourage maintenance of the stock, which otherwise faced deterioration; and improvement of already deteriorated units could be fostered by the rehabilitation program. This was seen as a way not only of increasing household satisfaction but also of promoting racial and income integration. Families could move out of concentrated minority-occupied, low-income areas.

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[2] U.S. Congress. Senate Special Committee on Aging. "Section 202 Housing for the Elderly and Handicapped: A National Survey." Committee print, 98th Congress, 2d session. Washington, DC, U.S. Government Printing Office. 1984.

Fear was expressed by opponents of this reliance on existing housing that: In places with low vacancy rates, rents would be driven up for all renters, particularly those of lower income who did not receive a subsidy; in some places there might be an absolute shortage of standard-quality rental units relative to the number of subsidized households; even if there were apparently a sufficient number of units, vacant units might not match the needs of particular types of households, such as large families. As the program has operated, further concern has been expressed that if the acceptable rent is held at a relatively low level, it prevents the dispersion of low-income families out of innercity areas. Even before section 8 was adopted, HUD had undertaken an Experimental Housing Allowance Program to test the feasibility and advisability of providing a rental subsidy for use in the existing stock. The analysis of this experiment has suggested that rents are generally not increased by the subsidy. Opponents of the shift to exclusive or predominant use of existing housing in subsidy programs, however, maintain that the results are not conclusive. This is due primarily to the alleged unrepresentative nature of the cities in which the market experiment was conducted.

The Reagan Administration has enjoyed considerable success in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market.

The Mortgage Revenue Bond [MRB] Program and other rental housing investing tax subsidies have come under increasing attack from the Reagan Administration and Members of Congress concerned about abusive tax shelters and tax-motivated construction not justified by market conditions. The administration's tax reform proposal, introduced in May 1985, would retain most homeownership provisions (but not the deduction for State and local property taxes), although lower tax rates would lessen their value to taxpayers who itemize their deductions. However, virtually all rental housing incentives, including the MRB program, would be ended. The MRB program, in particular, has led to the establishment of State housing financing agencies, some of which have established innovative housing programs for the elderly.

(2) Vouchers

As an alternative to conventional public housing programs, the Reagan Administration supports a system under which low-income families receive vouchers similar to food stamps. These can be used to pay for housing on the private market. The voucher is used to subsidize the difference between 30 percent of the family's income and the fair market rent of a suitable sized unit, although the actual rent may be more or less than the fair market rent. These vouchers were originally to be used principally in conjunction with the New Rental Rehabilitation and Development Program established under the Housing Act of 1983. This association, however, has been ended by the fiscal year 1986 Appropriation Act.

Advocates of the voucher program argue that, like the section 8 certificate programs, the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost than a new construction program. In their view, it would, on the one hand, provide an incentive to families to search for lower, though standard quality, rental units. On the other hand, it would permit those who valued housing highly to rent better quality or larger units by paying more of their income for rent. Recipients of section 8 certificates do not have this option. Moreover, since the contract is for 5 years rather than 15, less budget authority need be appropriated in any 1 year for the same number of assisted families.

Proposed shifts to direct cash assistance could bring some potential problems for the elderly in need of housing assistance. Some voucher system proposals would only pay the difference between 30 percent of income and some fair market rent determined for the area. The result of such a program could be that recipients end up paying more than 30 percent of their income for rent. This would be especially difficult for the elderly, many of whom are on fixed incomes. In addition, it is uncertain whether the elderly could find housing which meets their special needs, such as accommodation for wheelchairs and grab rails in bathrooms, in the private market.

The voucher system has been met with skepticism by Congress and many housing advocates. Critics of the program point to a shortage of decent low-cost housing in the largest cities. They question whether vouchers will provide real help to those most in need or simply encourage private landlords to increase rents because they know tenants have additional funds available. Since the vouchers are only authorized for 5 years, critics also raise the point that they do not represent a commitment to providing housing for the poor. They believe the budget savings are illusory, since the need will continue and, presumably, additional funds will be appropriated to continue assistance at the end of the 5-year period. The fiscal year 1985 Appropriation Act funded 42,000 vouchers, of which 38,500 are incremental and 3,500 for replacement of lost section 8 and public housing units. Fiscal year 1986 appropriations included 39,500 additional vouchers. In fiscal year 1987, $1.03 billion has been appropriated to fund 53,500 additional housing vouchers.

(3) Low Income Targeting, Tenant Rent Contribution

The Omnibus Budget Reconciliation Act of 1981 also reduced the income eligibility limit to 50 percent of the median income in the local area. The previous limit was 80 percent. This excluded 10 percent of those admitted to units available before the act and 5 percent of those who rented units becoming available after the act.

The percentage of those with incomes from 50 to 80 percent of median admitted to previously available units was increased from 10 to 25 in 1983, but 5 percent was kept for those becoming available after the act. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only. The continued eligibility of current tenants with incomes above 50 percent of median was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1984.

There have been complaints that HUD has implemented these regulations in an inflexible manner. The House housing bill, H.R. 1, contained a provision that would have eliminated income restrictions on housing assistance, but the bill was not passed by Congress.

Report language regarding the targeting issue was included in the Senate committee report (Report 99-129, pp. 14-15) accompanying the housing appropriations bill passed in August. This language directed HUD to use more flexibility when seeking to retroactively restrict admissions to a lower income mix. As the funding for section 202 housing becomes increasingly difficult to obtain, there will be continued efforts by some to focus the limited resources on the very poorest. This may be difficult to do with opposition in the House and because the program has historically served a more middle- and low-income population.

(4) Handicapped Setaside

Another issue that resurfaced during consideration of H.R. 1 is the allocation of section 202 moneys between elderly and handicapped housing projects. The House housing authorization bill for fiscal year 1986, (H.R. 1), includes an amendment adopted in subcommittee that established a setaside of section 202 funds of either 15 percent or $100 million, whichever is greater, for handicapped projects.

Those supporting the setaside argued that there is a need for separation from the elderly projects due to unique problems faced by handicap facility sponsors. In addition, handicap advocacy groups submit that such projects have been underfunded by HUD in the past. Also, average processing time for handicapped applications is 2½ to 3 years versus 23 months for elderly projects, due, in large part, to site location problems experienced by sponsors.

Elderly housing advocacy groups showed some concern that the guarantee of floor of $100 million could result in curtailed funding for elderly 202 projects during years of fiscal cutbacks. Mandatory cuts which could be implemented under a proposal like the Gramm/Rudman/Hollings measure could shift the proportion of elderly versus handicapped projects substantially away from the elderly. Although the Senate did not pass a housing authorization bill, it appeared likely that the $100 million floor would not have been included in the Senate bill, and that the handicap advocacy groups would be satisfied with the 15 percent guarantee for 202 project funds.

(5) Cost Containment

Cost containment requirements in the 202 program may work to change the program from providing housing with supportive services for the elderly to one of providing only minimal housing. Recent changes made to the section 202 program in order to increase the cost-effectiveness of the program and allow more units to be built with the same amount of money include requirements that: (1) Section 8 recipients in 202 projects pay 30 percent—instead of 25 percent—of the household's adjusted income for rent; (2) at least 25 percent of the units in a project be efficiencies; and (3) sponsors limit the size of the units, congregate space, and number of amenities. The establishment of maximum sizes for apartment units and community spaces removes much of the flexibility in design required to meet the changing needs of an aging population. To serve a more frail, elderly population, sponsors need a facility designed with smaller units and more congregate space. Policies of rigidity rather than flexibility may virtually eliminate the possibility of developing a proper facility for an increasingly frail population.

In June 1984 the U.S. General Accounting Office began a review of the HUD section 202 elderly housing program at the request of Senator John Heinz. The focus of the study was to examine the effectiveness of HUD's efforts to control costs through its cost containment requirement; to identify additional opportunities for reducing costs; and to establish the characteristics of the program's beneficiaries.

The analysis conducted by GAO is based on a review of HUD records for 179 projects at 10 HUD field offices, visits to 47 of these projects, and data on 802 section 202 projects obtained from HUD's Computer Underwiting and Processing System. The study was limited to projects primarily serving the elderly.

GAO's 1986 final report reveals that although cost containment efforts had been successful in lowering costs, cost containment was having some undesirable effects.

Analysis of construction cost data revealed that cost containment projects averaged 16 percent less than the average cost of units in projects built before cost containment. Section 202 loans ranged from 9 to 25 percent less per unit and GAO estimated that these reductions lowered project rents an average of 10 percent. GAO concluded that without cost containment, 202 project for fiscal year 1985 would have cost an additional $100 million.

There were problems related to the cost containment efforts. Units were, on average, 11 percent smaller; there were more efficiencies, which are less popular than one bedroom apartments; and fewer amenities for the residents.

One of the most significant issues raised by the study relates to the use of fair market rents [FMR] which HUD establishes for an area on the basis of rents tenants are willing to pay for housing. GAO found that FMR's for a particular area play an important role in the ability of the project sponsors to provide quality housing for the elderly. Project rents cannot exceed 120 percent of the FMR's HUD established for an area. The income from project rents is used to pay for a project's operating and maintenance expenses and to amortize project financing cost (principle and interest). Consequently, by controlling the rental income which can be collected, FMR's serve to limit the mortgage financing or loans and, in turn, the projects' construction costs. This makes it difficult for 202 sponsors in areas with relatively low FMR's to provide housing consistent with higher FMR areas.

FMR's preclude the construction of some projects built in one area from being built in another because their cost would be too high. In some cases FMR's for efficiency units required project sponsors to reduce construction costs by amounts greater than that saved by building efficiencies instead of one bedroom apartments. Another unfair scenario arises when projects in some States are exempted from real estate tax and can afford to use more of the project's rents for financing construction instead of taxes.

GAO discovered that although HUD requires projects with rents in excess of 100 percent of FMR's to comply fully with HUD's supplemental cost containment guidelines, projects with rents within 100 percent did not comply. In fact, no attempt was made to determine whether a project's features were excessive in some cases. Projects with rents over 110 percent were required to be reviewed by HUD headquarters for compliance.

The study also revealed inconsistent application of cost containment. GAO found that FMR's were difficult to establish for newly constructed units because comparables are not available, and adjustments are subjective and prone to error and abuse. Past problems at HUD with establishing FMR's were reported by GAO in 1980 and included improper documentation and arithmetic errors.

HUD field offices were found to have waived the 25 percent efficiency requirement in some cases and 18 percent of the cost containment projects reviewed had no efficiency units. Furthermore, projects receiving waivers were not required to meet the HUD space requirements.

GAO found that program costs could be reduced further. They estimated that HUD could save an additional $19 million annually if the number of efficiencies reflected the projected single elderly population expected to live in the projects. Efficiencies are estimated to average $2,800 less to construct than one bedroom units, and 80 percent of the tenants in the sample were single when they moved into their projects. Not all elderly are provided with the same amount of space, but all tenants pay the same rent (30 percent of income) regardless of the type of unit they occupy. Even though efficiencies are less expensive to construct, sponsors have little incentive to include more efficiencies than HUD requires (25 percent) in view of the effect of the lower FMR's for efficiencies can have on project construction cost and financing.

The survey pointed out further inconsistencies in that project costs differed widely within HUD field offices for both the same and different structural types. For example, in one office, high-rise elevator projects cost an average of 31 percent more per unit to construct than low-rise elevator projects. And for high-rise and low-rise elevator projects, per unit cost varied within each category by 18 and 20 percent, respectively. HUD instructed field offices not to consider project cost in the selection process. Projects with characteristics known to reduce costs, such as smaller units, more efficiencies, or low-rise construction, did not receive any additional points toward the modest design goal than projects without these features.

Critics of the HUD construction requirements for cutting costs say that they are so stringent that some of the new buildings are too poorly constructed to last the 40-year term of the mortgages. Therefore, amenities like meeting halls and hobby centers, which draw the elderly into a community, are being sacrificed. In conclusion, these initial findings strongly suggest that there are cost containment issues that must be resolved in order to provide the most elderly with suitable housing, given the limited funds available for the section 202 program.

(B) BRICK AND MORTAR VERSES SUPPORTIVE SERVICES

During a period when the Federal commitment to provide housing is in question, some concerns have been raised about the need for additional supportive programs. The primary Federal focus on the "brick and mortar" aspect of housing fails to address the supportive service needs of those being assisted. Further, this emphasis tends to discourage the development of other shelter alternatives that incorporate such services.

(1) Congregate Housing Services

Since 1971, PHA's have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. (No subsidy was to be provided to cover the cost of meals and other services.) To date, there has been little development of these congregate facilities. A study on long-term care released by the Department of Health and Human Services in late 1981 cited a variety of reasons for this, including: Local housing agencies have had little experience in managing the necessary services; there has been little Federal encouragement and support; and there is no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local services agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

The Congregate Housing Services Program [CHSP] was set up to be a demonstration program, with $20 million to be spend over a 5-year period. HUD is to evaluate and report to Congress on the success of this program. The program's chief function is to help the elderly remain in the rented dwellings as they age, rather than be institutionalized. As of December 1985, there were 68 congregate projects housing approximately 3,000 persons nationwide. Preliminary evaluation of the CHSP indicates it serves those individuals most in need and is more cost effective than formal institutionalization.

The stated philosophy of section 202 housing is to foster independent living. Section 202 projects were not intended to be either intermediary care facilities or standard apartment rental units. Instead they were meant to provide shelter plus services which are appropriate to the needs of the elderly and handicapped. Although they were originally designed to serve healthy elderly, survey results show that the majority of 202 tenants are aging in place and are now in need of more supportive-type services than when they entered the projects. Survey results reveal that the average age of a tenant living in one of the older 202 project is 78, while the average age of a tenant living in a project built under the new program is only 71. Results also indicate that, overall, 17 percent of these tenants are considered by project administrators to be frail.

Although an average of six on site services are offered per project, the types of services (such as personal care and housekeeping) that will enable this aging-in-place population to remain independent are offered on a very limited and fragmented basis.

There is no section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs however they chose. In the future, Congress will need to develop uniform guidelines to ensure that 202 sponsors will provide supportive service to help their aging populations to remain in their dwellings as they age, rather than to be institutionalized.

In 1985, 28 million people (11.8 percent of the population) were 65 years of age or older. Of these, 1.5 million were living in nursing homes. Since the disabilities of nursing home residents vary from old age to severe handicaps, many of these people may be candidates for congregate housing. While there is no way of precisely estimating the number of elderly persons who need or prefer to live in congregate facilities, various aging organizations have estimated that a large number of people over the age of 65 and not living in institutions or nursing homes would choose to relocate to congregate housing if possible. In addition, there are often reports of elderly occupants of nursing homes and other institutions who had no other choice of residence due to lack of alternatives adapted to different levels of independence, even though they did not require skilled nursing care.

In recent years, Congress has been appropriating funds for the maintenance of congregate housing projects already in existence. For fiscal year 1987, Congress has appropriated $3.4 million to keep these projects in operation. Sponsors of congregate projects fear that unless the congregate services program is made permanent with steady funding, the program will not survive.

Since funding for housing programs has been reduced in recent years, some States have established their own congregate housing programs in an effort to provide their elderly citizens with needed care without relying on Federal funds. A number of these State programs are described in a Congressional Research Service report issued in October 1986. In the last few years, private developers have shown a growing interest in development of congregate housing. Congregate housing appears to be a viable alternative for housing the semi-independent elderly. Since the HUD Congregate Housing Program was designed as a demonstration program, its future is uncertain, particularly in these times of limited funding. The cooperation of State governments and private entities may be necessary to secure the provision of shelter and services available under congregate housing.

(2) Mandatory Meals

Current policy enables HUD to give 202 sponsors the discretion to adopt a mandatory meal program that requires residents to purchase at least one meal per day, as a condition of occupancy. This policy limits the number of meals, but nonetheless permits the mandatory nature of participation. HUD views it as a compromise between protecting residents' rights and independence as well as ensuring their nutrition, and protecting sponsors' housing-and-services ideal.

To put the issue in perspective, a March 1985 GAO study found that only 512 of the 903 sponsors of 202 projects offer meals programs, and only 98 of those are mandatory. Seventy percent of residents participating in the mandatory programs report that they are satisfied with them, and 80 percent of all residents in mandatory programs would not leave the program if permitted. Only 17 percent of residents dislike the mandatory meal program, 12 percent indicated neither like nor dislike.

Many advocated for the elderly object to this program. They believe that forcing a resident to participate in a meal program when he or she could and would prefer to prepare his or her own food appears to be an infringement of individual rights, and contradicts the support for elderly independence to which 202 sponsors are dedicated. Residents' complaints about mandatory meals are mostly about the taste of the food or its cost (averaging $3.21 per meal). Complaints are based on individual preference, and do not seem to follow a pattern. A correlation does not exist between complaints about excessive meal costs and either the actual cost of meals in a project or an individual's income. Sentiments against mandatory meals is strong enough to have led to court cases, although the complaints are always in the minority. In one project serving 300, for example, only 15 residents filed court cases. (The court has always ruled in HUD's favor, as prospective tenants are informed of the mandatory meal policy before signing the lease.)

The adequate nutrition of elderly residents is a primary concern of 202 sponsors, and many aging advocates support the mandatory meal program concept. Many residents do not take the time, have the interest, or even remember to properly nourish themselves. Furthermore, as they age in place, residents are increasingly unable to prepare meals for themselves. Twice as many residents over 80 experience this difficulty, compared to those between 62 and 79. Consequently, more residents over 80 (77 percent) liked the mandatory meal program, compared to those between 62 and 79 (64 percent). It is possible that as the younger residents (who now dislike the policy) age, they may find themselves increasingly in need of and grateful for the service.

Isolation is another problem of the elderly addressed by this program. Mandatory meals encourage residents to get out of bed, get dressed and leave the isolation of their rooms for the more social atmosphere of the dining room. Daily meals also help project sponsors conduct informal "resident checks," thus aiding in awareness of which residents are ailing or missing.

It is evident that there are benefits derived from meal programs, but there is some question about whether it is necessary to maintain the mandatory status of existing programs, in order to offer a meal program. Ninety-two percent of mandatory meal managers believe that they could not continue to provide meals if forced to make the transition to a voluntary program. At the very least, they believe that meal prices would increase. The reason is that mandatory meals, which receive no Federal money, are running with a very small profit margin—94 percent of mandatory programs make a profit of less than 10 percent, and 33 are operating at a loss. The number of voluntary meal participants varies widely from day to day, which would make it difficult to run cost-effective programs. Eighty-nine percent of mandatory program managers say they could not run their current programs cost-effectively with even a 10-percent decrease in participation.

Currently operating mandatory programs were established in good faith with HUD's permission, and some argue that forcing them to make what is predicted to be an unsuccessful transition to voluntary status is unfair. The GAO has advised against prohibiting these programs, acknowledging the risk of eliminating meals programs entirely.

H.R. 1, introduced in the 99th Congress, contained a provisions which would have excluded certain individuals from the mandatory meal requirement, but the bill was not passed by Congress. The issue, however, is very likely to be revisited.

(3) Prepayment

Probably the most discussed issue concerning the section 202 program is that of prepayment of the loans. In the last 2 years, HUD has received numerous requests from borrowers of old section 202 loans for permission to prepay their loans in full. The reasons for prepayment vary. In some instances, the borrowers argue that many projects are more than 20 years old and have suffered extensive deterioration as maintenance has been deferred. With many of these projects heavily in debt and unable to raise rents to support the cost of repairs, the project owners say that they have no way of rehabilitating the premises. Owners claim that if they were allowed to prepay their loans, the projects could be sold to profit-motivated owners who could afford private financing for needed repairs.

Other borrowers say that prepayment of loans should be permitted on projects no longer essential to the community. These are projects which were supplanted as newer projects have been constructed. Borrowers believe that if they were permitted to repay the loans, their projects would be converted to other uses, still leaving adequate housing in the area for the elderly.

Prepayment could result in projects being converted to condominiums. This would cause the displacement of elderly tenants or cancellation of the agreement between HUD and the owner. Also, there would be no way to ensure the project was operated in the best interest of the elderly and handicapped.

Taking prepayment's impact on tenants into consideration, HUD recommends that early prepayment of loans be seriously reviewed and justified. Following this line of thought, Congress has made it clear that HUD was not to approve the prepayment of any loan unless it was ensured that the project would provide rental housing for present and future tenants as required by the terms of the original loan agreement. But as many of the housing units reach the 20-year mark, owners may, without Government approval, repay the mortgage in advance and then use or dispose of the property in any way they want.

In the August 2, 1986, issue of the National Journal, W. John Moore writes that, over the next decade, as many as 800,000 units of privately owned, federally subsidized rental housing could vanish. The National Association of Home Builders believes that it would cost more than $130 billion to replace the existing stock. One of the reasons for this reduction is that many rent subsidies under section 8 are scheduled to expire, potentially displacing thousands of poor tenants. HUD officials believe that approximately 270,000 units are scheduled to expire between 1986 and 1996. Another reason is that as many of the units reach their 20th anniversary, owners can repay the mortgage in advance and can sell or redevelop the property to use as they wish. HUD estimates that 570,000 rental units could be lost through conversion of the units to other uses. Other estimates go as high as 1 million. GAO has estimated that by 1995, the combination of expiring rent subsidies and potential mortgage prepayments could reduce the inventory of privately owned low- and moderate-income rental house by 200,000 to 900,000.

Housing activists fear that a housing crisis is truly in the making. They note that this potential reduction comes at a time when Federal subsidies for low-income housing have been reduced 60 percent over the past 5 years, when tax reform has taken away much of the incentive to invest in low-income housing, and when HUD is not committed to building any new subsidized rental housing.

3. Legislation

The President's budget proposal for fiscal year 1987 sought reduction in all direct housing subsidies and construction of new subsidized units, while promoting the voucher program as the Federal method of housing assistance. Under the proposal, new budget authority for HUD programs was expected to decline by almost two-thirds. In addition, low-income housing assistance was to be cut by approximately 70 percent.

In 1986, very few pieces of legislation in the housing area were signed into law. The housing authorization bill, H.R. 1, was passed by the House, but its Senate counterpart was never brought to the floor. HUD appropriations were incorporated into the continuing resolution (Public Law 99-500). The Tax Reform Act of 1986 was also passed, and will undoubtedly affect the housing industry.

(A) HOUSING AUTHORIZATION

Authorization bills for 1986 were introduced in both the House (H.R. 1) and the Senate (S. 2507). The House bill was passed on the House floor, but the Senate never voted on its bill. The three major issues in H.R. 1 concerning the elderly were: A proposal to reduce the percent of the elderly's income paid as rent from 30 percent to 25 percent; establishment of a program to set-aside at least 15 percent of section 202 funds for housing nonelderly handicapped; and a change in the mandatory meals program of congregate housing which would exempt certain individuals from participation in the program.

(B) HOUSING APPROPRIATIONS

HUD appropriations for fiscal year 1987 are incorporated in the continuing resolution (Public Law 99-500). The Department received $601 million in contract authority and $7.8 billion in budget authority appropriations. This amount includes $1.4 billion for public housing modernization; $1.6 billion for section 8 (used in conjunction with section 202); $1.5 billion for section 8 certificates and moderate rehabilitation; $1.03 billion for housing vouchers; $200 million for major rehabilitation of new construction of public housing; $1.35 billion for public housing operating subsidies; and $299.5 million for rental rehabilitation and development. Loan authority for section 202 projects is set at $593 million, with an interest rate of 9.25 percent. This amount should fund approximately 12,000 new units of housing. Congregate housing was funded at $3.4 million.

(C) THE TAX REFORM ACT OF 1986

Most elderly homeowners should experience minimal impact in the housing area from the Tax Reform Act. Restrictions on the use of home equity could be of concern to some. The cost of homeownership is likely to increase for upper income owners with sizable mortgages since mortgage interest and property tax deductions will save them less tax with the new lower tax rates. However, offsetting this possible increase in their costs are the lower income tax rates, and lower interest rates that many housing analysts expect as a result of the new tax legislation. In addition, an estimated 6 million low-income households, some elderly, will no longer have to pay Federal income taxes.

While, on balance, the Tax Reform Act of 1986 reduces the tax benefits of investing in rental housing, there is an important exception to the rental loss limitation for small investors, and transition rules that will help current owners of rental housing adjust to the new law. Many investors will gain from the lower tax rates and other aspects of the new tax law. Rental vacancy rates of approximately 7 percent, the highest in almost 20 years, and nearly 15 percent in the South, will tend to keep rent increases down in the immediate years ahead.

Real estate markets are highly competitive and, in general, are expected to adapt to the new tax laws without major disruption. However, this is much less the case for low-income housing. It remains to be seen to what extent the new housing tax credits will maintain or increase the supply of low-income housing. The fact that these tax credits are available only for property placed in service during 1987, 1988, and 1989, and that Federal housing subsidy contracts begin expiring in 1988, may stimulate a major congressional reassessment of Federal housing policy for low-income households.

Some believe that low- and moderate-income housing will be losers under tax reform. The legislation will probably reduce individual investment in low-income housing because of lost tax benefits and may accelerate the loss of the supply of federally subsidized housing as they are converted to market. Experts doubt that corporate investors will fill the void. The future trend appears to be concentrated ownership of apartments by large institutions with national investment managers and developers. Low income housing programs may be left out in the cold on economic grounds alone.

4. Prognosis

In 1986, Congress continued its 5-year tradition of disagreement with the Reagan Administraton over housing policy. The legislators rejected White House proposals to eliminate most forms of housing assistance as well as drastic cut backs in public housing operating subsidies. Congress also rejected spending deferrals of 1986 funds that the administration planned to hold over until 1987.

Despite congressional resistance, Federal housing assistance meets only a small fraction of the housing needs of the low income elderly. Yet low income housing has taken deeper cuts than any other program providing aid to low income people. In addition, these cuts have come in the face of rising need.

While the role of the Federal Government still remains significant because of its prior subsidy programs, it is clear that the role is diminishing and will be limited in the future. State and local commitments to public housing are important, but vary widely, and many States do not have adequate resources to support programs. Although reductions in direct Federal spending on housing programs can be expected to result in some amount of replacement spending by the private sector, the mix and type will certainly be less oriented toward benefiting low- and moderate-income households and neighborhoods.

If we are to meet the goal of a decent home for every American family and individual, Congress must not acquiesce in proposals to terminate housing programs and congregate services for the elderly. It must also resist any further major reductions in operating subsidies for low rent public housing.

B. INNOVATIVE HOUSING ARRANGEMENTS

The single-family house, increasingly void of children, has come to represent the discrepancy between the needs of a burgeoning population of elderly homeowners and the lack of housing alternatives. Recently, several types of solutions to the problems of those elderly trapped in houses too large for their needs and too costly to maintain have surfaced. These include: Home equity conversion plans; shared housing and ECHO, or granny flat arrangements.

1. Issues

(A) CONVERTING EQUITY

Developers hoping to find a lucrative market among the increasing numbers of elderly in the United States are learning that their competition is not with the retirement home, but in the single-family home. Economists currently estimate that there is $630 million of equity tied up in the houses of people older than 65 and that, by 1990, that figure will reach $750 million. Thus, attention has been paid in recent years to financial arrangements which would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion plans [HECP's] offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. They could also provide funds to allow older persons to pay for needed support services, home maintenance, and other needs. Before HECP's, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

Homes are the most commonly held and most valuable assets older Americans have. Three out of every four elderly persons own their homes, and recent statistics indicate that 80 percent of these do not have a mortgage. The total value of the equity held by older Americans is over $600 billion. Equally as significant, a large proportion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

There are two distinct types of conversion plans—debt and equity—on which a variety a variety of models are based. Debt plans allow an older homeowner to borrow against home equity with no repayment of principle or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrower, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as reverse mortgages or reverse annuity mortgages [RAM's].

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the total loan is repaid to the State from the proceeds of the sale of the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays for the taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the downpayment can provide income beyond the land contract term. These plans are also referred to as sale/leasebacks.

The basic theoretical forms of HECP's have been established for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans have not been sufficiently attractive to borrowers.

(B) SUPPORTIVE ARRANGEMENTS

(1) Retirement Communities and Limited Care Facilities

The Federal Government is supporting several congregate care housing demonstration projects. In addition, a few States are establishing congregate housing programs. There is, however, little direct public assistance to fill the gap between totally independent living arrangements and health-care-oriented retirement communities. Accordingly, the private sector has stepped in to provide various options. These range from low-cost elderly housing, board and care facilities to relatively expensive life care and retirement communities. Retirement communities differ in the range of housing, social and health care services they provide. Most provides independent housing, congregate meals, and social and recreation activities. Some also have 24-hour nurse service and wellness clinics, and others provide a continuum of care that includes independent living units, personal care, and nursing home care services.

In the past, the Senate Special Committee on Aging has made a point of scrutinizing the Nation's estimated 300,000 board and care homes serving low-income older persons. The Aging Committee, in 1983, also conducted an investigative hearing on the benefits and shortcomings of the life care industry. One of the committee's major objectives in 1987 will be to learn more about the demand for, and the conditions in, the generally subsidized and loosely regulated area of semi-independent living for the elderly.

(2) Board and Care Homes

Most of the more than 1 million residents of boarding homes and foster, adult, or domiciliary care facilities receive some form of public assistance. Managers of the 300,000 such homes have often been criticized for inadequate safety and security measures, poor care, abuse of the residents, and even financial fraud.

In 1976, after a number of fires in board and care homes, Congress added section 1616(e), known as the Keys amendment, to the Social Security Act. This provision requires that for group living arrangements in which a significant number of SSI recipients reside, States establish and enforce standards that govern such matters as admission policies, safety, sanitation, and protection of civil rights. In making this change, Congress sought to prevent the Supplemental Security Income [SSI] Program from becoming a source of funds for substandard institutions.

The Keys amendment does not mandate Federal regulation or licensure of board and care homes. There is only one enforcement sanction available to punish provision violators—the power to reduce the SSI checks of residents of homes not in compliance with State regulations. This includes States with no regulations at all. Although all States now have health and safety provisions in law, Federal efforts to enforce board and care home standards have been hampered by lack of direct Federal funding of these facilities: SSI benefits are paid directly to board and care home residents or their representative payee, not the facility. This contrasts with nursing homes, where Federal Medicaid and Medicare Programs pay the provider of care directly. Consequently, the Federal Government has been able to achieve stronger regulatory requirements for skilled nursing and intermediate care facilities.

(3) Life Care Communities

Life care communities, also called continuing care communities, typically provide housing, personal care, and nursing home care, and a range of social and recreation services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of a resident's life. In its study on life care, the Pension Research Council of the University of Pennsylvania developed a definition of life care communities. It includes providing specified health care and nursing home care services at less than the full cost of such care, and as the need arises. Life care communities meeting this definition numbered about 300, with 100,000 residents, in December 1981. Life care defined in this way is viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more such services. Also similar insurance pricing policies, entrance fees usually are based on actuarial and economic assumptions, such as life expectancy rates and resident turnover rates.

Entrance fees range among life care communities from approximately $20,000 to over $100,000, and are based on such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. Life care communities do not cover acute health care needs such as doctor visits and hospitalization. Studies have shown that the average age of persons entering into life care communities is 75. In independent living units personal care units, and nursing home units the average ages are 80, 84, and 85, respectively.

About 97 percent of all life care communities have nonprofit income tax status. Many are affiliated with a religious organization, although the organization may not have legal responsibility for the communities' operations and financial solvency. In recent years, the for-profit sector has shown an increased interest in developing and operating life care communities.

There also are about 300 communities which require entrance and monthly fees of residents in exchange for specified benefits. These benefits, however, are not considered a form of long-term care insurance. While these communities have a range of housing, social, and health care services, including nursing home care, they do not cover the cost of most nursing home care services. Such care is paid for by the residents on a fee-for-services basis (as expenses are incurred).

Problems have been discovered in some communities. Some life care communities have functioned using lifespan and health projections that are not actuarially sound, as well as incorrect revenue and cost projections. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned even on a prorated basis. Recently, there has been a growth in the number of private nonprofit corporations which sponsor life care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation. For example, in order to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

While most life care communities are managed effectively, some have faced financial and other problems. A relatively and growing phenomenon, life care is just beginning to be understood and regulated. California, in 1969, was the first State to regulate life care. Today, only 13 States regulate the operation of life care communities. These States are: Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Michigan, Minnesota, Missouri, Oregon, Pennsylvania, and Virginia. New York, which bans prepaid nursing home care, effectively prohibits life care arrangements. There is little uniformity in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few if any of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures and non-armslength transactions to enhance his personal wealth at the expense of the life care residents.

The University of Pennsylvania's Wharton School study suggested that States, when regulating life care, should address issues such as: Facility certification and accreditation; management of escrow accounts; maintenance of reserve funds; required financial disclosures; strengthening preconstruction requirements for bond holders; and the development of methodologies to be used to test the ongoing financial viability of the community.

(4) Shared Housing

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored, where 4 to 10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually three of four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is that of a companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

According to census statistics, some 670,000 people over age 65 (excluding those who are institutionalized or in nursing homes) share housing with nonrelatives; a 35-percent jump over a decade ago. In a recent AARP poll of a sampling of its 23 million members on the subject of shared housing, 15 percent said they would consider sharing living quarters with someone outside their family.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. Dennis Day Lower, a director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost-effective when compared to new construction. He has noted that per unit capital costs could be as much as 50 to 60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced supplemental security income and food stamp payments to participants. Congress has recognized and begun to act on the need to overcome these impediments. They included a provision in the Housing Act of 1983 for section 8 rental assistance to be used with shared housing. Under this provision, the existing and moderate rehabilitation programs of section 8 can be used to aid elderly families in shared housing. HUD will issue minimum habitability standards to insure decent, safe, and sanitary housing as an eligibility activity under the Community Development Block Grant Program.

Several shared housing projects are in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities. It helps match people looking for an affordable place to live with those who have space in their homes and are looking for someone to aid with their housing expenses. Some of the people helped by Operation Match are single working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a linkage between individuals, groups, churches, and service agencies that are planning shared households.

(5) Accessory Apartments and Granny Flats

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Basically, accessory apartments are another form of shared housing, except that each unit has its own kitchen. Thus, this form of housing undergoes the same zoning restrictions and impediments already discussed in the section of this report concerning shared housing. According to one expert, about 40 percent of the single family housing stock in the country is now under zoning that permits accessory apartments. According to this expert, once zoning is changed, there are a large number of applications to legialize existing accessory apartments, but very few applications for new ones. The reason is that the homeowners must deal with local government zoning and building regulations, as well as with contractors, banks, and tenants. Unfortunately, the process is intimidating for many people and it is difficult to find reliable advice. The expert suggests a basic partnership between real estate agents and remodelers to market accessor apartments.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO" flat, first constructed in Australia and recently introduced in this country. "Granny flats" were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as "ECHO units," an acronym for elder cottage housing opportnity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

2. PROGNOSIS

Innovative housing programs will become more and more essential in providing basic housing and support services for our Nation's elderly, handicapped, and poor. But Congress, with its full platter of issues, is likely to focus much attention on innovative housing for the elderly in 1987. Hearings will be in order, but action on home equity conversion clarification and further life care facility policy is not a high priority. It is very unlikely that legislation on these issues will reach the President's desk for signature this year.

There should be strong growth of interest in, if not attempts to use, home equity conversion transactions. This concept has become very attractive to many of the large number of older Americans who have substantial equity in their homes yet are faced with meeting the high costs while living on fixed incomes. In addition, the life care industry is expected to grow by leaps and bounds over the next several years, mainly appealing to the upper middle and upper income groups. There is consideration being given to life care facilities for lower income Americans, primarily those that have been able to purchase a home during their lifetime. These efforts will be slow in evolving, however, and will be undertaken primarily by nonprofit life care interest. The for-profit life care interests will continue to expand during 1987.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence become a larger burden than many elderly can afford. The need for quality board and care facilities, accessory apartments, and granny flats will grow with the increase in the number of older Americans, but the role of the Federal Government will not be significant in 1987.

Chapter 10

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

During the 13 years since OPEC nations instituted the full scale embargo on oil sales to the United States, energy use and conservation have become major domestic policy issues, particularly with regard to the economic security of the elderly and poor.

A number of Federal programs have been instituted to ease the energy cost burden for needy individuals. The most significant of these are Low-Income Home Energy Assistance Program [LIHEAP] and the Department of Energy's [DOE] Weatherization Assistance Program. Over the years these programs have undergone modifications in response both to growing need and apparent deficiencies in design and implementation. They have also come under increasing scrutiny in the effort to reduce Federal budget deficits.

Although these two programs have played an important role in helping millions of America's poor pay for their basic energy needs and weatherize their homes, there is a widening gap between existing Federal resources and the needs of the population these programs were intended to serve. The Reagan Administration has been unsuccessful in its efforts in recent years to substantially cut LIHEAP and eliminate the DOE Weatherization Program. Congress has, for fiscal year 1987, continued to view these programs as the Federal Government's only significant efforts to assist the elderly and poor with their escalating energy costs and has maintained funding for them. They have, however, been subject to reduction because of the Gramm-Rudman-Hollings Act and on the basis of a recognition that significant additional money recouped from oil overcharges litigation will be available to States.

A. BACKGROUND

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in the household budgets of Americans. The proportions of income required to purchase essential energy supplies rose dramatically, and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirement, during the past 13 years the pressure for change in consumption patterns and the erosion of real spending power due to energy inflation has been unrelenting. The rising cost of energy has had a particular effect on the elderly and those with low incomes, who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel.

The rise in energy cost in relation to income has been the impetus behind congressional enactment of both the Low-Income Home Energy Assistance Program and the Weatherization Assistance Program. Between 1972 and 1979, electricity costs rose 84 percent, natural gas prices increased 150 percent, and fuel oil costs rose 258 percent. These figures were well above the overall increases of 74 percent in the Consumer Price Index for the same period.

According to the Department of Energy's residential energy consumption survey, beginning in 1979 and continuing for the next 2 years, the average household paid $100 more each year for household energy. In 1982, however, the increase slowed significantly. As pointed out by the DOE, this slowdown in the rate of increase occurred because the increase in prices was nearly offset by the decrease in consumption. Overall, price rose 14 percent from 1981 to 1982, while consumption dropped 10 percent.[1]

In the early 1980's fuel costs rose dramatically. Between December 1980 and December 1985, household fuel costs rose 32.6 percent. The trend had definitely slowed in 1985, however, as the average price of heating fuels increased only 0.7 percent between December 1984 and December 1985. The U.S Bureau of Labor Statistics reports that the consumer price index for household fuels actually declined 9.4 percent from December 1985 to December 1986. This figure reflects a 33.4 percent decrease in the cost of fuel oil, a 1.5-percent decrease in the cost of electricity, and a 5.8-percent decrease in the cost of natural gas.

The DOE has estimated that energy consumption is higher for households with larger incomes. There is a large difference in average energy consumption and expenditures among households with different incomes. The highest income households use about 70 percent more energy than the lowest income groups. It was noted that their living quarters are about twice the size of the lowest income group and they usually have more appliances. From 1978 to 1980, there was a trend toward parity, with high-income households lowering their energy consumption more than low-income households did. The data for 1981, however, show a slight reversal of this trend. Households earning less than $5,000 reduced their consumption by an estimated 11 million BTU, while households with incomes over $24,000 did not show a continued drop.

Rising energy prices affect all income groups, so that energy expenditures increased across-the-board from 1978 to 1981. Average expenditures for households in the highest income group ($1,333) were almost 75 percent more than those of the lowest income group ($766) in contrast, however, expenditures increased much more for the lower income group than for the higher.

During this 4-year period, beginning in 1978, expenditures for the lowest income group increased 47 percent, in nominal dollars, while expenditures for the higher income group increased 24 percent. Additionally, expenditures as a percentage of income are much higher for lower income groups. Low-income households typically spent about 20 percent of their income on energy, while high-income households spent from 3 to 4 percent of their income on energy. Among poor households, the burden of energy expenditures is highest in the Northeast and North-Central portions of the country. For example in the Northeast, poor households, below 100 percent of the poverty level, paid 29 percent of their income for household energy.

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[1] Energy Information Administration, 1978–82 Residential Energy Consumption Surveys.

The Department of Health and Human Services [HHS] estimates that the average heating expenditure for low-income households will be about $463 nationwide for fiscal year 1986. The estimated average heating expenditure is up 2 percent from the average heating expenditure of low-income households for fiscal year 1985. The everall increase in heating expenditures is due, according to HHS, to the combination of colder weather over most parts of the country and the slight increase for some fuels.

TABLE 10-1.—ESTIMATED AVERAGE EXPENDITURES FOR HEAT BY LOW-INCOME HOUSEHOLDS

	Fiscal year—		Percent change
	1985	1986	
National	452	463	+2
Northeast	660	687	+4
North Central	623	657	+5
South	288	294	+2
West	314	287	−9

The high cost of energy is a special problem for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, DC, has reported that experts on this subject estimate that hypothermia may be the root cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many pre-existing conditions and diseases in older adults, such as arthritis. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia.

In recent years, congressional efforts to ease the burden of high energy costs on the elderly and poor have taken two principal forms. First, since 1977, Congress has appropriated money to provide aid for fuel related emergencies to households at or below 125 percent of the poverty line. The Low-Income Home Energy Assistance Program grew from $200 million in crisis assistance in 1977, to $2.1 billion in fiscal years 1985 and 1986. In fiscal year 1987, the LIHEAP appropriation is $1.9 billion, $184 million less than that available in fiscal year 1986. Funds are distributed to States on a formula basis which takes into consideration climate and energy needs of the population.

Second, in 1975, Congress enacted the Emergency Energy Services Conservation Program, designed to provide energy relief to needy households by increasing the energy efficiency of homes through insulation and repairs. By 1985 this developed into a $191 million Weatherization Assistance Program operated and administered by the Department of Energy. In fiscal year 1986, revenues dropped to $178 million, reflecting reductions allowed under the Gramm-Rudman-Hollings measure. For fiscal year 1987, the DOE Weatherization Program anticipates having $144.3 million available.

1. THE LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

The precursors of the current Low-Income Home Energy Assistance Program [LIHEAP] were a series of 1-year programs in fiscal years 1977 to 1979 that were administered by the Community Service Administration [CSA]. Although the names and operation procedures of these programs differed year to year, they all were limited to a $200 million annual appropriation and oriented to crisis intervention. Generally, potential low-income recipients had to demonstrate that they faced an imminent energy-related emergency, such as a shutoff of their home heating fuel supply or a breakdown of their primary heating source. In such cases, aid could be provided to pay utility bills or provide in-kind benefits, such as space heaters or blankets.

Between the winter of 1979 and 1980, the price of home heating oil doubled In response, Congress expanded aid sharply by creating a three-part energy assistance program at an appropriation level of $1.6 billion: $400 million to the CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services [DHHS] for one-time payments to recipients of supplemental security income [SSI]; and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation. Enactment of this law was based on the perception that those who would potentially suffer the most under decontrol, would be aided. The act authorized $3.12 billion for LIHEAP in fiscal year 1981. During the appropriation process, however, the funding level and the distribution formula were changed. In its final form, $1.85 billion was appropriated, and the distribution to States was based on a complex formula that was heavily weighted toward States with cold climates and large fuel oil consumption.

There basic types of energy-related aid are permissible under the LIHEAP. First, States may make payments to assist households in paying their fuel bills for either heating or cooling. There are virtually no restrictions on the manner in which this assistance is provided (cash payment, vouchers, vendor lines of credit, and tax credits are the most common). Second, States must use a reasonable amount of their allotment to provide energy-related emergency assistance, as was provided under the old CSA crisis intervention program. Finally, States may use up to 15 percent of their allotments for low-cost weatherization, home heating or cooling, and energy-related emergencies. States may carry over up to 15 percent of their LIHEAP funds to the next fiscal year without affecting the calculation of future allotments. In an effort to provide greater flexibility, the law allows up to 10 percent of a State's allotment to be transferred from LIHEAP to other Federal block grant programs and, conversely, funds may be transferred into LIHEAP from other block grants.

At the discretion of the State, LIHEAP payments can be made to households where one or more persons are receiving: Supplemental Security Income, Aid to Families with Dependent Children, Veterans' Pensions, or Dependency and Indemnity Compensation. States can also elect to make payments to households with incomes that are less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Table 3 indicates the income ceiling of one-person households by State on the basis of the 60 percent median household determination for fiscal year 1986. Beginning in fiscal year 1986, States must not set income eligibility limits below 110 percent of the Federal poverty level. The income levels range from $6,715 in Arkansas to $11,930 in Alaska. In 1985 the alternate income ceiling, 150 percent of the poverty guideline, was $7,875 in all States except Alaska ($9,840) and Hawaii ($9,060). The ceiling in 1986 for a one-person household is $8,040 for all States except Alaska ($10,050) and Hawaii ($9,255).[2]

TABLE 10-2.—*60 percent of median income for one-person household in fiscal year 1986*

State:	
Alabama	$7,836
Alaska	11,930
Arizona	8,596
Arkansas	6,715
California	9,973
Colorado	10,075
Connecticut	11,763
Delaware	9,883
District of Columbia	8,954
Florida	7,941
Georgia	8,568
Hawaii	9,863
Idaho	7,490
Illinois	9,589
Indiana	8,400
Iowa	8,049
Kansas	8,601
Kentucky	7,518
Lousiana	8,721
Maine	7,543
Maryland	11,068
Massachusetts	10,604
Michigan	9,195
Minnesota	9,605
Mississippi	6,850
Missouri	8,670
Montana	7,887
Nebraska	8,143
Nevada	10,765
New Hamphsire	9,489
New Jersey	11,372
New Mexico	7,459
New York	9,528
North Carolina	7,913
North Dakota	8,214
Ohio	8,831

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[2] Federal Register, Vol. 51, No. 28. February 11, 1986. pp. 5150–5106.

Oklahoma	8,476
Oregon	8,238
Pennsylvania	8,821
Rhode Island	9,100
South Carolina	8,036
South Dakota	7,487
Tennessee	7,513
Texas	9,138
Utah	8,012
Vermont	7,938
Virginia	9,813
Washington	9,418
West Virginia	6,911
Wisconsin	9,041
Wyoming	8,886

According to HHS, States reported providing heating assistance to over 6.5 million households in fiscal year 1985. About 900,000 households received energy crises assistance, more often for heating than cooling. Based on previous estimates, HHS states that it appears that about two-thirds of the households reported as receiving heating crises assistance also received regular heating assistance. The unduplicated number of households receiving assistance with heating costs would be, therefore, about 6.8 million. This compares to the 6.8 million households assisted in fiscal year 1984. HHS also reported in 1986 that 500,000 households received assistance for cooling costs in fiscal year 1985 and that over 200,000 households received low cost weatherization or other energy-related home repairs.

According to the HHS report to Congress for fiscal year 1986, the average LIHEAP benefit for heating assistance was about $242. This offset about 57 percent of the average fiscal year 1985 heating costs for recipients. Average fiscal year 1985 space heating costs for all households were about $431, while average space heating costs for low income households were about $402, or about 7 percent lower than the average for all households. Average space heating costs for LIHEAP recipient households were about $427. On average, according to HHS, households receiving LIHEAP benefits have higher heating costs and lower income than low income nonrecipient households.

There remains a gap between those in need (those eligible) and those currently receiving LIHEAP benefits. Excluding individuals who may be categorically eligible for benefits (households where at least one individual is receiving food stamps, Aid to Families with Dependent Children, certain Veteran's benefits, or Supplemental Security Income), the Congressional Research Service estimates that 23.4 million households meet the income eligibility requirements for LIHEAP benefits. This estimate is based on the March 1984 Current Population Survey [CPS].

Unfortunately, HHS cannot estimate the number of households eligible for LIHEAP with precision. Typically, States operate LIHEAP for only part of the year and no data source provides seasonal national information on income and participation in other programs which provide categorical eligibility for LIHEAP. Further, States' procedures for determining eligibility may annualize 1 or more month's income to test against the income standard the State has adopted. Thus, households may be eligible for LIHEAP even though their actual annual income is above the income maximum set in law. With these qualifications, HHS estimates that for fiscal year 1985, about 22.8 million households had incomes under the maximums in the LIHEAP statute.

2. THE DEPARTMENT OF ENERGY WEATHERIZATION ASSISTANCE PROGRAM

The Department of Energy's [DOE] Weatherization Assistance Program has been authorized under the Energy Conservation and Production Act of 1976, as amended. Its authority expired at the end of fiscal year 1985, and for fiscal year 1986 it operated under a continuing resolution at $178 million, which reflected reductions under Gramm-Rudman-Hollings sequestration. The program is designed to reduce heating and cooling costs in homes of low-income households.

Through the program, funds are made available to States, which in turn allocate dollars to nonprofit agencies for purchasing and installing relatively low cost materials such as insulation, storm windows, doors, and other such materials. Federal law allows a maximum average expenditure of $1,600 per household in a State. To be eligible for assistance, household income must be at or below 125 percent of the Federal poverty level ($9,050 for a family of two as specified in the 1986 Federal Poverty Income Guidelines). States, however, may raise their income eligibility criterion to 150 percent of the poverty level to conform to the LIHEAP income ceiling. They may not, however, set it below 125 percent of the poverty level. Also eligibile for assistance are households with persons receiving AFDC, SSI, or local cash assistance payments. Like LIHEAP, priority for assistance is given to households with an elderly individual (age 60 and older) or a handicapped person. The program has served 1,489,562 million homes from the program's inception through September 1985. Approximately 728,604 of these homes had a person age 60 or older. In fiscal year 1985, 185,000 homes were weatherized.

Among the program's intended benefits are:

—improved energy efficiency in the homes of program recipients,
—reduced fuel bills for program recipients,
—reduced national energy consumption, and
—increased employment opportunities in areas related to installing and manufacturing low-cost weatherization materials.

A DOE-sponsored evaluation of the Weatherization Assistance Program published in 1984 (based on 1981 data) showed that:[3]

—The program reaches elderly persons in accord with its statutory priority requirement.
—The program saves, on the average, about 13 percent of a home's heating energy. The study found that 50 percent of the weatherized homes surveyed had an energy savings of 10 percent or more; 23 percent had a savings of 20 percent or more; and 23 percent used more energy the year after weatherization.

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[3] U.S. Department of Energy. Energy Information Administration. Office of Energy and End Use. Weatherization Program Evaluation. SR-EEUD-84-1. August 20, 1984. Executive Summary and pp. 1-2, 18-19.

—Energy savings relate to the type and cost of weatherization assistance materials. Homes receiving the most extensive weatherization services, insulation plus storm windows or doors, saved more than twice as much energy as weatherized homes that were not insulated. Insulation was a key measure for producing energy savings in the homes weatherized.

—Energy savings derived from a particular energy improvement, however, can be precisely determined only by measuring energy consumption under identical circumstances before and after the improvement is made. This condition is impossible to meet because conditions are always changing. For example, thermostat settings and energy use in a home changes from year to year.

—More of the homes weatherized are in colder weather zones and fewer are in temperate and warm weather zones.

As a result of these findings, DOE has begun to examine those elements of occupant behavior that most strongly contribute to differences in energy savings as well as the combination of weatherization materials that optimizes energy savings.

Beginning in calendar year 1987, DOE will establish a performance fund from which dollars will be awarded to States meeting its criteria for the best weatherization programs. From 5 to 15 percent of the amount appropriated each year for the DOE program will be used for the fund. Dollars awarded in 1987 will come from the fiscal year 1986 appropriation. The award criteria relates to the percentage of eligible dwelling units within a State that have been weatherized, energy savings resulting from weatherization activities, and the State's actual achievement of its weatherization assistance program goals.[4]

B. ISSUES

1. Evaluating Energy Assistance and Savings

Of primary concern to the Special Committee on Aging is the effectiveness of energy assistance programs in serving older persons. Both LIHEAP and the Weatherization Program require that elderly and handicapped citizens be given priority in receiving assistance, to assure that these households are aware that help is available, and to minimize the danger of unnecessary shutoff of utility services. Specific data on the number of older beneficiaries continues to be unavailable. Changes to the law relaxed many of the reporting requirements, and, as a result, many States opted to no longer maintain age-specific data. According to HHS, about 39 percent of households receiving assistance with heating costs had an elderly member; this is about the same proportion of elderly among all eligible households. Thus, households containing elderly members are served roughly in proportion to their representation in the total low income population. Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be utilized as information and outreach bases for the programs. Discussions with area agencies on aging and senior center staff indicate that increased effort has been made in recent years to identify eligible elderly persons for energy assistance, and to provide the general elderly population with information regarding the risks of hypothermia.

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[4] Federal Register. Part V. Department of Energy. December 5, 1985. p. 49912.

The effectiveness of LIHEAP and the DOE Weatherization Program continues to be a debated issue. Many argue that the programs have been well directed to the neediest, yet conclusive data is not available.

According to a report prepared by the Economic Opportunity Research Institute for the National Association of State Community Services Programs, frail or disabled elderly people, the very poor, and households with a history of energy shutoffs are in greater need than many households who receive energy aid. About 2.8 million such households, with average incomes of $2,196, are not served. Households that receive aid under LIHEAP on average have higher incomes and lower energy costs than eligible households not receiving the aid. The report stated that meeting the needs of those not currently served under LIHEAP requires more money. Using 1984 average benefits, achieving a 55 percent participation rate would require 23 percent more LIHEAP funds.

Proponents of LIHEAP cite continuing need for low-income assistance. Home energy prices continue to be high. Although home heating oil prices have decreased 22 cents per gallon since 1981 (as of August 1985), they have not receded to their pre-1979 levels. In addition, prices for natural gas rose significantly in the 1980's. The consumer price index for household fuel rose 32.6 percent between December 1981 and December 1985.

According to the 1986 HHS report, low income households expend a greater proportion of their income for space heating than do other households. The percentage of income for heating is greater still for low income recipient households. The average annual income of low income recipient households is about 14 percent less than the average annual income of other low income households. Nationally, fiscal year 1985 heating costs represented about 5.4 percent of the average income of low income households and 6.6 percent of income for LIHEAP recipient households, compared to about 1.6 percent of income for the average U.S. household.

LIHEAP however, has had its critics. Those opposed to LIHEAP generally take one of two positions. One position argues that the public welfare system, excluding LIHEAP, is already either sufficient or too generous. Another position is that assistance is needed, but not in the form provided by LIHEAP.

Those who oppose specific energy aid for low-income individuals contend that, when combined with other welfare benefits, LIHEAP increases work disincentives, unnecessarily increases the Federal deficit, and makes the cumulative benefits under all welfare programs too generous (especially since LIHEAP benefits are not counted as income for determining eligibility and benefit levels under other means-tested assistance programs). It is also argued that LIHEAP was intended to be only a temporary emergency measure, designed to help households cope with the energy price shocks of the 1970's and should not become part of the permanent public welfare system.

Among those who favor energy-related aid for those with low incomes, but not in the manner of LIHEAP, there are two principle schools of thought. Some maintain that assistance would be more efficiently provided through the more established means-tested programs such as AFDC, SSI, or food stamps. Others argue that LIHEAP, by increasing household income available for energy, discourages energy conservation. The twin goals of helping low-income households meet high energy costs and encouraging energy conservation would be better achieved, some assert, through home weatherization or renewable energy home improvements. It also is argued that LIHEAP benefits often do not make low-income households any better off. Instead, in many areas, benefits are paid directly to utility companies, reducing what would otherwise be bad debts. It should be noted, however, that there is no strong evidence that a significant portion of those receiving LIHEAP benefits would not have paid their fuel bills in the absence of LIHEAP.

Various studies have attempted to quantify energy savings resulting from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing conditions of dwelling units and varying climatic conditions and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in homes that have been weatherized. Experts in this area have noted that most studies do not use control groups where fuel costs in homes weatherized are compared with fuel costs in homes not weatherized. Lacking a control group, it is difficult to accurately predict whether changes in energy consumption are due entirely to weatherization assistance, or in part to changes in fuel prices, conservation programs, appeals from political leaders, or some combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States which administer the DOE program. While DOE has claimed a 20- to 25-percent annual energy savings in homes weatherized through its program, GAO reports that this statistic has questionable reliability because of DOE's sampling and data problems.[5]

A study conducted in the State of Minnesota on it's weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded that the DOE program was successful in reducing energy consumption, on average, by 13 percent. The study also concluded that the cost of weatherization is likely to be repaid in terms of lower fuel bills within 3½ years.[6]

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[5] U.S. Government Accounting Office. Uncertain Quality, Energy, Savings and Future Production Hamper the Weatherization Program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. October 26, 1982. Washington, 1982. pp. 18-20.

[6] Hirst, Eric and Raj Talwar. "Reducing Energy Consumption in Low-Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, V. 5, October 1981. pp. 671-683.

Although this evaluation initially showed promise for a careful examination of energy savings, the GAO reported that the study was too geographically limited to reveal savings on a nationwide basis. In the final analysis, GAO has concluded that there is no nationwide study on cost savings which incorporates standardized statistical methods in a way to assure maximum reliability. However, the evaluation discussed earlier in this chapter under the DOE Weatherization Program description was conducted after GAO's analysis, and provides further evidence that the program is working.

2. Block Grant Versus Categorical Funding

Another issue under consideration regarding the energy assistance programs concerns the issue of block grants versus categorical grants in the Federal Weatherization Program. Many public officials agree that the Federal Government should support weatherization activities for low-income households. The nature of this support, however, is somewhat controversial. While some groups favor the block grant approach to Federal assistance, others find more merit in the categorical grant approach like the DOE program.

For fiscal year 1986, the President recommended phasing out the DOE program, which would leave the LIHEAP block grant as the primary source for federally funded weatherization assistance. Congress, however, did not act on the President's recommendation, and funded the program in fiscal year 1986 at nearly its fiscal year 1985 funding level. The General Accounting Office reviewed the program and found that priority for weatherization is lower in the block grant programs, which could result in fewer homes being weatherized. GAO noted that a lack of restriction on how funds may be used could result in communities not effectively targeting funds to address the greatest need. Additionally, GAO stated that no evidence existed to support the notion of reduced costs and improved quality under the block grant approach.

States have statutory authority to transfer to LIHEAP up to 10 percent of their social services block grant allotments and up to 5 percent of their community services block grant allotments. To date, however, no State has transferred such funds to LIHEAP. On the other hand, the LIHEAP statutes provides that a State may transfer up to 10 percent of the LIHEAP funds payable to it for fiscal year for use in 1 or more of the 6 other block grants administered by HHS. Thirty States transferred a total of approximately $98.1 million in LIHEAP funds to these block grants in fiscal year 1985.

C. LEGISLATION

Despite efforts by the Reagan Administration to block grant LIHEAP and eliminate or phase-out the Weatherization Program, Congress has steadfastly resisted changes. For example, in the 1984 budget request, the Reagan Administration proposed replacing LIHEAP with a block grant to States, and requested no funding for the Weatherization Assistance Program. It also proposed to dismantle the Department of Energy. Although Congress studied numerous energy assistance proposals, it rejected the administration's approach and continued the program at essentially the same as during fiscal year 1983.

1. Low-Income Home Energy Assistance Program

The President's fiscal year 1985 budget recommended that Congress reauthorize LIHEAP through fiscal year 1989 with an annual authorization of only $1,875 billion, $200 million below the fiscal year 1984 appropriation. In addition, the administration proposed funding the program from the petroleum overcharge restitution fund [PORF] as opposed to general revenues. The Senate and House of Representatives again rejected the administration's proposal, and instead, reauthorized the LIHEAP program as part of the Human Services Reauthorization Act (Public Law 98-558). The law extended the program for 2 additional years. In fiscal year 1986, the Reagan Administration refrained from attempting to cut LIHEAP.

(A) REAUTHORIZATION OF LIHEAP

The administration's fiscal year 1987 budget request assumed extension of the appropriations authorization of LIHEAP, as did the fiscal year 1987 congressional budget resolution (S. Con. Res. 120). To implement the extension of authorization of LIHEAP appropriations, the administration submitted draft legislation that proposed to: (1) Extend the appropriations authorization for 3 years at $2.1 billion for fiscal year 1987 and with no specific authorization levels for later years; (2) remove the 15 percent limit on the proportion of a State's allotment that may be devoted to weatherization assistance; (3) repeal the requirement that States describe home energy usage within each State in their annual application for an allotment; (4) require States to take into account other assistance available to LIHEAP beneficiaries when establishing their LIHEAP benefits; (5) revise the method of calculating and providing special LIHEAP grants to Indian tribes; and (6) changes certain nondiscrimination provision of LIHEAP law. Congress chose to design reauthorization legislation that, in effect, ignores many of the administration's recommendations.

In the House of Representatives, H.R. 4422, the Low-Income Energy Assistance Amendments of 1986 was introduced by Representative Kildee and jointly referred to the Committee on Education and Labor and the Committee on Energy and Commerce. On April 25, 1986 the Committee on Education and Labor reported it with amendments (H. Rept. 99-556, part 1), but it was not reported by the House Energy and Commerce Committee and was not taken up by the full House.

In the Senate, the Human Services Reauthorization Act amendments of 1986 (S. 2444, S. Rept. 99-327) was approved on July 14, 1986, and included a reauthorization of LIHEAP appropriations. It was approved as the Senate's version of H.R. 4421 which, as passed by the House, provided reauthorization for a number of programs but did not include LIHEAP. Since the House did not take up H.R. 4422, H.R. 4421 served as the vehicle for reauthorization of LIHEAP appropriations and of any amendments to the law governing LIHEAP. The provisions of H.R. 4422, however, were under consideration in the conference on H.R. 4421.

On September 12, 1986, House-Senate conferees on H.R. 3321 reported their agreement (H. Rept. 99-815). This agreement was enacted as Public Law 99-425 on September 30, 1986. It included the following provisions:

—a 4-year reauthorization of appropriations for the LIHEAP, the authorization level increasing 4 percent a year:

	Billion
Fiscal year 1987	$2.050
Fiscal year 1988	2.132
Fiscal year 1989	2.218
Fiscal year 1990	2.307

—provisions stipulating time deadlines that must be met in delivering energy crisis aid and making it clear that community based organizations such as community action agencies may be designated to administer energy crisis intervention programs;

—revisions in the method of calculating and providing special LIHEAP grants to Indian tribes;

—provisions emphasizing the requirement that States adjust benefits to ensure that the neediest households receive the maximum assistance;

—provisions reorganizing State plan requirements and directing the development of a "model" State plan;

—a requirement for an annual report on the LIHEAP; and

—provisions stipulating that receipt of LIHEAP benefits in no way influence eligibility or benefits under the Food Stamp Program. (See Food Stamp chapter for details.)

(B) FUNDING LIHEAP

Congress authorized $2.3 billion for LIHEAP in fiscal year 1986 while only $2.1 billion was actually appropriated. Since LIHEAP was subject to a 4.3 percent reduction under Gramm-Rudman-Hollings (Public Law 99-177), the amount actually available was reduced to $2 billion.

In its fiscal year 1987 budget request, the administration originally requested $2.1 billion for the program. It later reduced the request to $1.9 billion. The congressional budget resolution for fiscal year 1987 assumed that Congress would provide $2 billion, based on "current services" estimates projecting oil price decreases.

When the House of Representatives took up the fiscal year 1987 Labor-HHS-Education appropriations bill (H.R. 5233), Congress had not acted to extend the appropriation authorization for LIHEAP beyond fiscal year 1986. As a result, the House version of H.R. 5233 contained no amount for LIHEAP. The Senate version of H.R. 5233, however, proposed a fiscal year 1987 LIHEAP appropriation of $1.8 billion. The House-Senate conference agreement on H.R. 5233 (reported October 2, 1986) provided the amount proposed by the Senate—$1.8 billion.

Before both Houses approved the conference agreement on the Labor-HHS-Education appropriation bill, the measure was included with all other appropriations bills for the year in a fiscal year 1987 continuing resolution (H.J. Res. 738). The continuing resolution, which provided $1.8 billion for the LIHEAP program, was signed into law on October 18, 1986 (Public Law 99-500).

A number of factors influenced the fiscal year 1987 appropriation level—Projected prices for home energy; the interaction between the formulas which allocate LIHEAP funds among the States and the appropriation level; and the additional funding available to the States from recouped oil price overcharges.

(1) State Allotments

Although a new formula for allocating LIHEAP appropriations among the States was enacted in the 1984 amendments to the Low-Income Energy Assistance Act, the method of allocating funds actually varies according to the appropriation level. As a result, changes in appropriations can produce what appear to be anomalous differences in State allotments. In fiscal year 1986, some States experienced a decrease in their allotments because LIHEAP was subject to a Gramm-Rudman-Hollings spending reduction of 4.3 percent. Under the LIHEAP allocation procedures, 23 States received no reduction, 7 States and the District of Columbia received the standard 4.3 percent fiscal year 1986 Gramm-Rudman-Hollings reduction, and the remaining 20 States received cuts ranging from 4.6 percent to 11.7 percent. This was criticized by many as contrary to the uniform "across-the-board" intent of Gramm-Rudman-Hollings and a bill was introduced that would have directed uniform percentage cuts in State allotments when funding reductions are caused by Gramm-Rudman-Hollings procedures. Reductions in State allocations will occur again in 1987 because the annual LIHEAP appropriation is less than that of the previous year.

(2) Recouped Oil Price Overcharges

In addition to Federal appropriations for the LIHEAP, significant amounts of money have and will be available to States from oil price overcharges recouped in court settlements under the Emergency Petroleum Allocation Act of 1973 (Public Law 93-159). States may use those moneys for LIHEAP and for four other energy-related conservation programs.

The first of these funds, some $200 million held in escrow by the Energy Department, was distributed in early 1983. The money is allocated among the States according to each State's share of the national usage of petroleum products during the period of the oil price overcharges involved in the court settlement. According to HHS, States have reported using about $49 million of these funds for the LIHEAP during fiscal year 1983 through 1985, and $1.5 million in fiscal year 1986.

In July 1985, an oil price overcharge decision against the Exxon Corp. was upheld, with an award of $2.1 billion against the corporation. In March 1986, the Energy Department released the award to the States according to the usage of petroleum products. It is too early to determine the extent to which States will use this money for LIHEAP. Most recently, a July 1986, Federal district court ruling approved a settlement in the "Stripper Well" case that may make an additional $400-$500 million available to the States.

The availability of money from recouped oil price overcharges has become an issue with regard to LIHEAP. To the extent that States have access to this money and use it to fund LIHEAP efforts, it is argued that Federal appropriations can be frozen or reduced. Indeed, the Senate reduced the fiscal year 1987 appropriation in recognition of the oil price overcharge. Further, some argue that any Federal share of the recouped overcharges should be earmarked to fund LIHEAP and that legislation should be enacted to recoup, for the Federal Government, a substantial share of any settlements.

Those who disagree with these concepts argue that the availability of oil overcharge funds should not affect appropriations for LIHEAP or the low income weatherization program. They state that oil overcharge funds are neither Federal or State funds, but represent lost resources by purchasers across the country as a result of illegal action. Since they are intended to remedy past injuries, they should be applied in a way that addresses those past injuries and should not be used to replace current funds in on-going Federal programs. They also argue that through the Warner amendment, Congress made the oil overcharge money available to the States to be used in addition to, not instead of, existing Federal and State money for five designated Federal programs.

It is expected that substantial sums will be made available to States over the next several years as more overcharge cases are settled and as moneys from other cases, already held by the Energy Department, are distributed. It is uncertain what effect recouped oil price overcharges will have on Federal appropriations over the long term and on State support for the LIHEAP beyond Federal allotments of LIHEAP funds.

(3) Projected Prices for Home Energy

The Senate Appropriations Committee's proposal for a $1.9 billion fiscal year 1987 appropriation was based on an assumption that fiscal year 1987 home energy costs will be about the same as in fiscal year 1982, when the appropriation was $1.9 billion. The amount actually appropriated, $1.8 billion also reflects this assumption.

(C) WEATHERIZATION

In his fiscal year 1986 budget request to Congress, the President recommended a $152.9 million funding level for the DOE Weatherization Program with a plan to phase out the program over a 5-year period. The President also recommended helping States develop strategies for conducting weatherization activities without Federal assistance during the phase out period. In response to this recommendation, DOE began to help States with techniques for carrying out weatherization activities without Federal funds and awarded 38 "opportunity grants" ranging from $40,000 to $60,000 each to State and local agencies for demonstrating strategies to weatherize homes with non-Federal funds. Congress, however, has not acted on the President's request to phase out the program. In 1986, the DOE Weatherization Assistance Program operated under a continuing resolution at $190.1 million, just below its fiscal year 1985 funding level of $191.1 million.

For fiscal year 1987, the President proposed phasing out the Weatherization Assistance Program in future years and funding was proposed to come from settlement of petroleum pricing violation cases. The DOE Weatherization Program anticipates having $144.3 million available in 1987.

D. PROGNOSIS

There is clear evidence that Federal energy assistance programs have been successful in meeting the emergency relief and basic energy needs of millions of elderly and poor Americans. These programs have also reduced the energy expenditures for many of the poor through weatherization assistance. The level of the programs' success and their philosophical appropriateness, however, continue to be debated.

Nonetheless, the energy expenses of the elderly and poor will continue to grow during the next decade, creating a wider gap between their need and the Federal Government's response. According to the Community Action Foundation [CAF] 4 million households had utility service terminated for nonpayment in 1982. To prevent service terminations from increasing and to keep the percentage of real income devoted to energy by the poor at a manageable level, billions of dollars in assistance will be needed. CAF estimates that if energy costs grow 2 percent per year, the eligible population would need $7.3 billion in 1989, just to keep purchasing power constant.

The Alliance to Save Energy has demonstrated that cost-effective low-income conservation programs are possible through installation of new heating system technologies. The development and field testing of much of the new heating system technologies was supported through Federal research and development efforts. Funding for these research activities has been decreasing in recent years, even though these investments in research could result in saving elderly households millions of dollars in energy costs. The availability of research funds will play an important role in determining future conservation successes.

In the past 3 years, many regulated gas and electric utilities have been required by their State public utility commissions to undertake low-income and elderly conservation programs. This new development may have a positive effect on the energy conservation needs of all elderly persons. This approach encourages greater State and local control and funding of such conservation activities.

It is unlikely that the administration will recommend or the Congress will enact appropriations at levels to meet eligibility and research needs. In fact, it is probable that both LIHEAP and the DOE Weatherization Assistance Program will be targeted again in fiscal year 1988 by either the administration or Members of Congress for cuts or elimination. Continued congressional support and expanded private efforts will be needed to preserve the current minimal level of assistance available to those who lack the means to meet their basic energy requirements.

At this time it is unclear what impact falling oil prices will have on consumers of home heating fuels, but fuel oil and electricity costs to consumers continued to rise in 1986. It is possible, however, that some LIHEAP and DOE Weatherization Assistance beneficiaries will need less assistance if prices fall substantially, and these savings are passed on to the consumer. On the other hand, reductions in heating costs may simply allow these Federal resources to provide energy and conservation aid to more of the millions of low-income households that are eligible for assistance, but remain unserved.

Chapter 11

OLDER AMERICANS ACT

OVERVIEW

Since its enactment, the OAA has evolved from a program of small grants and research projects to a network of 57 State units of aging, over 660 area agencies on aging, and thousands of community organizations providing supportive social and nutritional services to older adults. At the same time, appropriations for programs under the act have increased from $6.5 million in fiscal year 1966 to $1.2 billion for fiscal year 1987.

Congress has reaffirmed its support for programs under the Older Americans Act on 11 occasions through passage of various amendments and reauthorization action. The most recent reauthorization of the act occurred during the 1984 fiscal year. Responding to time pressures prior to adjournment, as well as a pervasive feeling that Older American Act programs were operating effectively, Congress made only minor adjustments to the act. The new amendments in the act were signed into law by President Reagan on October 9, 1984 (Public Law 98-459). (For a full discussion of the 1984 amendments, see Developments in Aging: 1984, vol. 1.)

Fiscal year 1986 was legislatively uneventful for the Older Americans Act [OAA], but Congress began the 1987 reauthorization process with hearings in both the Senate and House. Congress continued to show its strong support of the OAA programs by reinstating the presequestration funding levels in the budget process, and by increasing appropriate levels for title III support and nutrition services programs.

There remains, however, growing concern from some OAA loyalists, both service providers and recipients, that deficit reduction actions are a sign that very few programs will escape the budget cutting ax in the months and years ahead. Program cuts could result in pressure to prioritize titles and programs within the OAA, and to target services. To date, the close link between OAA dollars and direct services that millions of older Americans receive appears to have helped to protect OAA funding.

A. BACKGROUND

1. History of the Older Americans Act

For the past 21 years, the Older Americans Act has served as the cornerstone of Federal involvement in a wide array of community services to older persons. Created during a time of rising societal concern for the needs of the poor, the act marked the beginning of a categorical approach to programs specifically designed to meet the social and human needs of the elderly. The act itself was one of a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvment was needed beyond the income transfer and health programs. Although older persons could receive services under a multiplicity of other Federal programs, the act became the first major vehicle for the organization and delivery of community-based social services to the elderly.

The Older Americans Act followed on the heels of a similar but somewhat more expansive grouping of social service programs initiated under the Economic Opportunity Act of 1964. With a similar conceptual framework to that embodied in the Economic Opportunity Act, the Older Americans Act was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When first enacted in 1965, the OAA established a series of broad policy objectives designed to meet the needs of older persons. These objectives, however, lacked both legislative authority and adequate appropriations to be truly effective. Despite its limited scope and funding—providing for a Federal Administration on Aging and making minimal grants to State units on aging—the act established a structure through which the Congress would later expand aging services.

Funding for the OAA grew slowly during the 1960's, but during the 1970's Congress followed up on improvements in income transfer programs with significant modifications in services to the elderly. In 1973, for instance, Congress enacted significant expansions in services provided under the Older Americans Act to provide for the establishment of area agencies on aging, and in 1974 created the national nutrition program for the elderly. Fiscal years 1978 and 1980 saw further improvements in the level of financial support directed toward Olders Americans Act programs, the development of the structures for providing community-based services [AAA's], and the added emphasis on the provisions of certain priority services—access, in-home and legal services.

This expansion trend continued until the early 1980's when, in response to the Reagan Administration's policies to cut the size and scope of many Federal programs, the growth of overall OAA spending was slowed and, for some programs, was reversed. Major budget cutting emphasis during this time, however, was placed on reductions in the income transfer and health programs (i.e., Medicare and Medicaid). The focus on the larger money items helped deflect budget cutting measures aimed at programs such as the Older Americans Act, although they were not entirely untouched. For example, between fiscal years 1981 and 1982, title IV funding for training, research, and discretionary programs in aging was reduced by approximately 50 percent. In addition, appropriations for title III, supportive services, and congregate and home-delivered meals (excluding the U.S. Department of Agriculture program), declined slightly from 1981 to 1982, from $624.7 million to $606.6 million. From 1983 through 1985 funding has increased at an annual rate less than the rate of inflation. The fiscal year 1987 appropriation is 6.4 percent higher than the fiscal year 1986 level, and the Congressional Budget Office forecast for the rate of inflation in 1987 is 4 percent. Widespread congressional support for other OAA programs, especially nutrition and senior employment, has served to protect them.

Congress has rejected some Reagan Administration proposals for reductions in Older Americans Act programs in various budget submissions since 1981, most notably the administration's attempt in fiscal year 1983 to eliminate the community service employment program under title V. Congress has also rejected administration proposals to consolidate appropriations for the supportive services, and congregate and home-delivered nutrition service components under title III, and to transfer the U.S. Department of Agriculture [USDA] commodity program from the Department of Agriculture to the Administration on Aging [AoA]. (The 1987 budget submission did not contain proposals to consolidate title III services or to transfer the commodity program to (AoA.) With respect to the title IV research, training, and demonstration program, the administration's fiscal year 1987 budget reduction request of $12.5 million was a more moderate reduction request than in previous years. In fiscal years 1984 and 1985 the request for this program was $5 million.

Despite administration efforts, OAA programs have been spared funding reductions experienced by other social services programs. Table 1 shows that appropriations for the period fiscal year 1980 to fiscal year 1987 have increased from $993 million to $1.2 billion. This represents a 20-percent increase. The only funding decreases occurred from 1981 to 1982, and from 1983 through 1985 funding increased at an annual rate less than the rate of inflation. The fiscal year 1987 appropriation, however, is 6.4 percent higher than the fiscal year 1986 level. The decline in funding levels during the early 1980's was partially due to the rather substantial cuts in the title IV program for research, training, and demonstration projects. Title IV declined by some 59 percent during the 1980 to 1982 period. Title III supportive and nutrition services also declined slightly from 1981 to 1982.

TABLE 11-1.—*Older Americans Act Appropriations,*[1] *1980–87*

Fiscal Year:	*Millions*
1980	$993
1981	1,040
1982	1,006
1983	1,098
1984	1,124
1985	[2] 1,155
1986	1,165
1986 (after sequestration)	[2] 1,117
1987 (administration's proposal)	1,147
1987	1,188

[1] Includes appropriations for all titles, except Section 311 USDA commodities program for which obligations of funds as shown in Budget Appendices are included.

[2] Includes fiscal year 1986 urgent supplemental funds for the USDA elderly commodity program.

Over the years, the essential mission of the Older Americans Act has remained very much the same: Provide a wide array of social and community services to those older persons in the greatest economic and social need in order to foster maximum independence. The key element in the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization.

States and area agencies on aging constitute the administrative structure for programs under the act. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system that will best meet these needs. Beyond this mission, and as originally conceived by the Congress, this system was meant to encompass both services funded under the act, and services supported by other Federal, State, and local programs. The concept of resources mobilization and coordination was an important element in the early development of the act.

2. The Older Americans Act Amendments of 1984

The following is a brief description of each title of the Older Americans Act as amended in 1984.

(A) DECLARATION OF OBJECTIVES—TITLE I

Title I sets forth the national objectives for older Americans particularly for improving their income, health, housing, and community services opportunity.

(B) ADMINISTRATION ON AGING AND FEDERAL COUNCIL ON AGING—TITLE II

Title II establishes the Administration on Aging (AoA) within the Department of Health and Human Services (DHHS) and the Federal Council on Aging. The Council was first authorized in the 1973 amendments to the act. Federal Council appropriations reached their height in fiscal year 1976 and declined for most years since that time.

(C) GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING—TITLE III

Title III authorizes grants to State agencies on aging to develop a comprehensive and coordinated delivery system for supportive services, nutrition services, and multipurpose senior centers for older persons. This system is intended to assist older persons attain maximum independence in a home environment, to remove individual and social barriers to economic and personal independence, and to provide services and care for the vulnerable elderly. Since original passage of the act in 1965, the title III program has evolved from simply a funding source for social service programs to a planning vehicle for the development of a comprehensive and coordinated service system for older persons. Significant amendments in 1969, 1973, and 1978 broadened the scope of operations and established the basis for a "network" on aging under the title III program umbrella.

The title III nutrition meals, is one of the most visible federally funded social service programs for older persons, and represents about 47 percent of total Older Americans Act funds in fiscal year 1987, including the elderly commodity program. The supportive service component, which funds a variety of social services, such as ombudsman, in-home, legal, and access services, represents about 23 percent of the act's total fiscal year 1987 funding.

Funds for State administration, supportive services, and senior centers, congregate and home-delivered nutrition services are allotted to State agencies on aging based on the State's share of the 60 and over population as compared to all States, with minimum amounts for the territories. State agencies, in turn, award funds to area agencies on aging for administration within specified planning and service areas. Area agencies provide funds to agencies and organizations for the delivery of a wide range of supportive services (with special emphasis on access, in-home, and legal services), and congregate and home-delivered nutrition services. The law requires that preference be given to serving older persons with the greatest social or economic needs with particular attention to low income minority older persons. Means tests as a criterion for participation are prohibited.

State agencies on aging also receive U.S Department of Agriculture [USDA] commodities or cash in lieu of commodities, to supplement the costs of providing meals under title III. The law requires USDA to provide State agencies an annually programmed level of assistance that is based on the number of meals served with title III funds. The USDA reimbursement is provided on a per meal basis in an amount adjusted for inflation to reflect changes in the Consumer Price Index for food away from home. While the law provides for the distribution of commodities, most States have opted to receive a combination of cash in lieu of commodities as well as commodities to supplement meals provided under the title III program.

Appropriations for title III services and State administration increased by 25 percent for the period 1980–87 (including amounts for USDA commodities). (Excluding amounts for USDA commodities, the increase was 17 percent.) Although Congress appropriated specific amounts for supportive services, and congregate and home-delivered nutrition services, the act allows States to transfer funds between these separate categories. The 1984 amendments to the act increased the ability of States to transfer funds between these separate amounts. The 1984 amendments allow a State to transfer up to 30 percent in fiscal year 1987. In addition, the act allows States to transfer funds between the congregate and home-delivered nutrition service categories. In recent years States have increasingly shifted funds between these three separately appropriated amounts, with a notable shift of funds from the congregate nutrition program to other service components. For example, in fiscal year 1986, $47 million was transferred from the congregate nutrution appropriation to other title III services. The 1984 amendments also changed the manner in which funds for the State administration are made to States by consolidating funds for this purpose under the title III services amounts. Since fiscal year 1985, States do not receive a separate allocation of funds for State administration, but are allowed to use up to 5 percent of their allocation for title III services or $300,000, whichever is greater, for administration.

According to data reported by States to the AoA, the number of supportive service participants has remained virtually the same for the period 1980-85, at approximately 9 million participants each year. The number of meals served, supported by title III as well as other funds available under auspices of the program, increased 37 percent from 167 million in fiscal year 1980 to over 229 million in fiscal year 1986.

(D) TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS—TITLE IV

Title IV of the act authorizes appropriations for training, research, and demonstration programs in the field of aging. Under the training authority, the Commissioner on Aging is required to award grants or enter into contracts for activities related to the recruitment of personnel, in-service training for those employed in aging services, and technical assistance activities. It also authorized grants for multidisciplinary centers of gerontology.

Under the research authority, the Commissioner may support a wide range of projects related to the purpose of the act as well as conduct evaluation activities.

Under the demonstration authority, the Commissioner is authorized to conduct model projects to demonstrate methods of improving or expanding supportive or nutrition services or other services to promote the well-being of older persons. The Commissioner is required to give special consideration to certain projects such as those designed to meet the special needs of the rural elderly and supportive service needs of persons with Alzheimer's disease and other neurological and organic brain disorders.

The Commissioner is required to conduct demonstration projects relating to legal services for older persons. In addition, the Commissioner is authorized to conduct special demonstrations in comprehensive long-term care, projects which would relieve the excessive burdens of high utility and home heating costs, and other projects having national significance.

Appropriations for title IV reached their height in fiscal year 1980 at a level of $54.3 million. This program has experienced the greatest reduction of any Older Americans Act program in recent years, with a decline of 59 percent from the fiscal year 1980 level of $54.3 million to $22.2 million in fiscal year 1982. Appropriations remained at that level in fiscal year 1983 and fiscal year 1984, and increased slightly to $25 million in fiscal year 1985. The fiscal year 1986 funding level fell to $23.9 million as a result of the Gramm-Rudman-Hollings sequestration. The title IV fiscal year 1986 funding level represents about 2 percent of total Older Americans Act funds. In fiscal year 1985 the program supported 300 grants and contracts. An estimated 31,500 students were trained in academic aging programs and 241,000 State and area agency and service provider personnel received in-servicing training.

(E) COMMUNITY SERVICE EMPLOYMENT PROGRAM FOR OLDER AMERICANS—TITLE V

The program's purpose is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. The basis for the current program was a demonstration program created during the 1960's under the Economic Opportunity Act [EOA]. Modeled after operation mainstream, a pilot project authorized under title II of the EOA, it was first funded in 1965. In 1967, administrative responsibility for operation mainstream was transferred from the Office of Economic Opportunity to the Department of Labor [DOL] but funding authority continued under the EOA. In 1973 the program was given a statutory basis under the Older Americans Act amendments. The program continues to be administered by DOL, which awards funds to national organizations and to State agencies to operate the program.

Until 1984, the program had seen steady increases in funding and participant enrollment since its inception. In 1974, the first year the program received an appropriation under the Older Americans Act, participant enrollment was 3,800 with an appropriation of $10 million. Appropriations for fiscal year 1986 of $312 million are estimated to support about 61,000 employment positions (to cover the period July 1986–June 1987). (Note: the program is funded on a "forward-funded" basis; that is, funds appropriated for a given fiscal year are to be used beginning on July 1 of that fiscal year and ending on June 30 of the following year.)

Although persons 55 years or older are eligible for the program, priority is to be given to placing persons 60 years or older in community service jobs. Their income must not exceed 125 percent of the poverty level guidelines issued by DHHS (in 1986, $6,875 for a 1-person household). Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is higher. Participants may work up to 1,300 hours per year and average 20–25 hours per week. For the 1984–85 program year the average hourly wage paid to enrollees was $3.47. In addition to wages, enrollees receive annual physical examinations, personal and job-related counseling, and some job training.

Participants work in a wide variety of community service activities. In the 1984–85 program year, about 61 percent of job placements were in the services to the general community while over 39 percent were in services to the elderly. The program provides substantial support to nutrition programs for the elderly, primarily funded under title III of the Older Americans Act and administered by State and area agencies on aging. About 10.3 percent of the employment opportunities in title V aging services placements were in nutrition services. Other job areas in aging services were in recreation/senior centers and outreach and referral services. In services to the general community, enrollees were placed primarily in education and social service activities.

Funds are allocated to national organizations and to State agencies on aging. National organizations that receive funds are Green Thumb; American Association of Retired Persons; U.S. Department of Agriculture's Forest Service; National Caucus and Center on Black Aged, Inc., Association Nacional Pro Personas Mayores; and the National Urban League. In alloting funds DOL is required to reserve a "hold harmless" amount to enable the national organizations to maintain their 1978 level of activities. No more than 45 percent of funds exceeding the 1978 level of appropriations is to be awarded to national organizations and allocated among States according to a formula which takes into account the number of persons 55 years of age and over and per capita income. The remainder of funds in excess of the 1978 level of appropriations is to be distributed to State agencies on aging according to the same formula. In addition to this formula, appropriations legislation has, in the past, contained requirements regarding the distribution of funds to national organizations and States. Appropriations language has required that national organizations receive 78 percent of funds and State agencies receive 22 percent.

(F) GRANTS FOR INDIAN TRIBES—TITLE VI

The purpose of the title VI program is to promote the delivery of supportive and nutrition services to older Indians which are comparable to services offered to other older persons under title III. The program received its first appropriation in fiscal year 1980. In fiscal year 1986 awards were made to 133 tribal organizations.

(G) OLDER AMERICANS PERSONAL HEALTH EDUCATION AND TRAINING PROGRAM—TITLE VII

The 1984 amendments added a new title to the act which required the Secretary of Health and Human Services, through AoA, to award funds to institutions of higher education to design and implement standardized health education and training programs for older persons. No funds were appropriated for fiscal year 1985, requested for fiscal year 1986 or 1987, or appropriated for either of those years.

B. ISSUES

The Older Americans Act appears to be headed for a fast-paced May 1987 reauthorization, about 4 months prior to its September 30 deadline. The act was last authorized in 1984.

A number of issues have been developing over the past few years which are likely to surface in the House and Senate hearings, mark-ups, and floor action that will take place this year.

1. TARGETING OF SERVICES

A major issue that will continue to be debated in the coming years, especially in light of the large deficits, is whether the OAA should be amended to focus more narrowly on certain subgroups of older persons. During 1984 reauthorization hearings on the act, some witnesses suggested that, in view of the limited resources available under the program and the special needs of certain groups of older persons, the act should be targeted to such groups.

Congress has resisted targeting in the past. Title III, for example, currently requires that preference in providing supportive and nutrition services be given to those older persons with the "greatest economic or social needs." Despite this, and regulations which require that special attention be given to certain economic and ethnic groups, the distribution of title III funds to States is based solely on the number of older persons in the State. In fact, Congress has prohibited use of a means test for determining eligibility for title III services, and has always maintained that the act is open to all older persons in need of services. In addition, States are required to distribute funds acccording to a formula taking into account the geographical distribution of persons 60 years and over. AoA regulations require the State's intrastate funding formula to reflect the proportion among the planning and service areas of older persons with the greatest economic or social needs.

During the first session of the 98th Congress, the Senate Labor Committee's Subcommittee on Aging held a hearing on the issue of targeting resources based on economic or social need. Testimony ranged from those who claim the current legislation provides sufficient flexibility for State and local agencies to serve targeted groups, to those who support specific setasides to minorities, Indians, and individuals with limited ability to speak English. One witness expressed the view that targeting be based on the concept of functional capacities of older persons.

In response to these concerns, the 1984 amendments made two changes designed to strenthen the "greatest social and economic need" provision. First, the amendments required States to publish a more detailed disclosure statement on their funding formula. In making this change, the Senate Committee on Labor and Human Resources noted:

> This requirement is intended to increase public knowledge of how a State agency has planned to distribute all resources made available under the act and to target resources to specific groups of older persons, as well as to increase State accountability for its funding decisions.[1]

The second change in the law was to require that State and area agencies provide assurances that special attention will be given to "older minority persons."

The OAA is one of many domestic programs that will have to fight for its share of the scarce resources available for such programs in the remainder of the 1980's and beyond. The Older Americans Act lost 4.3 percent of its total fiscal year 1986 funds as a result of Gramm-Rudman-Hollings and future cuts are possible as Congress continues to attempt to meet deficit targets through fiscal year 1991. OAA advocates will, at the least, need to fight to keep funding up with inflation.

This scenario leaves OAA proponents two primary options if faced with fewer dollars: (1) Support reductions in titles and programs in OAA across the board, possibly forcing some programs to become so small as to be unworkable; or (2) support targeting the available resources toward a particular segment or segments of the older population.

The targeting choice is offensive to some OAA advocates from the outset because they believe that the program's popular support and lack of welfare stigma result from the broad availability of title III programs. Many believe that a restricted or means-tested title III, designed to target only the very poorest, for example, could sour the national and congressional attitude toward the program. This could lead to further reductions in funding in the future. On the other hand, some contend that only social programs for the very poorest will survive the budget-cutting process.

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[1] U.S. Congress Senate Committee on Labor and Human Resources. Older Americans Act of 1984. May 18, 1984. Report No. 98-467, p. 11.

The wide range of goals set forth under the Older Americans Act are not practically achievable with $1 billion or even $2 billion per year. Therefore, some argue that the programs should focus on a smaller number of needs, and that they should address them more fully. Targeting could direct OAA funding at those who are most in need, but deciding who should select and prioritize the neediest groups and the types of programs to serve them is a much more difficult problem to solve.

The issue of getting the most from our limited dollars toward improving the quality of life for the elderly will be especially important in the coming years. Some will opt for targeting instead of accross-the-board reductions. Others will not accept the "inevitability" of OAA reductions and will continue to strive for the expansion of the program that is necessary to fulfill its stated goals.

(C) COMMODITIES PROGRAM REIMBURSEMENTS

As mentioned earlier, under section 311, State agencies on aging receive from the USDA, commodities, or cash in lieu of commodities, to supplement approriations for congregate and home-delivered nutrition services. Current law requires USDA to provide States an annually programmed level of assistance that is based on the number of congregate and home-delivered meals served under auspices of the title III program. The level of reimbursement is made on a per meal basis in an amount adjusted for inflation to reflect changes in the Consumer Price Index. The 1981 amendments to the Older Americans Act placed, for the first time, an authorization ceiling on the program, and required the Secretary of Agriculture to reduce the per meal reimbursement level in any year in which the cost of the program would exceed the authorized level (that is, would exceed the total of the number of meals served multiplied by the per meal reimbursement level). The 1984 amendments to the act established the following authorizations in appropriations: Fiscal year 1985, $120.8 million; fiscal year 1986, $125.9 million; and fiscal year 1987, $132 million.

Because of the stipulation in the law that the per meal reimbursement rate be reduced when the cost of the program is expected to exceed the authorization level, USDA took action to reduce the rate based on its projections of increased numbers of meals to be served in fiscal year 1985. On February 21, 1985, USDA published a notice in the FEDERAL REGISTER[2] that the per meal reimbursement rate originally estimated for the program for 1985, 58.75 cents, would instead be 56.76 cents. USDA projected that the number of meals to be served during fiscal year 1985 would be 212.8 million, which, if reimbursed at the estimated per meal rate of 58.75 cents would result in a program cost of $125.020 million, $4.22 million over the fiscal year 1985 authorization level of $120.8 million. USDA indicated that the reduced per meal rate of 56.76 cents would keep the cost of the program under the authorization ceiling. Subsequent to the February notice, USDA announced on

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[2] Federal Register, vol. 50 no. 35, p. 7203.

August 19 [3] that further action to reduce the per meal reimbursement level may be necessary. This announcement was made based on further projected increases in the number of meals to be served during fiscal year 1985. The August announcement indicated that the number of meals to be served during fiscal year 1985 would range from 220 million to 230 million. To keep the cost of the program within the autorization ceiling specified by the law, USDA stated that the per meal reimbursement rate could have ultimately been between 52.52 cents and 54.90 cents.

The uncertainty which these and other changes in per meal reimbursement rates creates for the States and local nutrition providers can have a negative impact on the program. States and providers must wait until after the end of the calendar year to find out what reimbursement rate they will receive for meals that they have already provided and reported by the end of December. This creates a situation in which States and meals programs may hold back on the number of meals they provide until the last quarter of the year.

This problem may be resolved in the near future; the USDA has been working on a proposal to allocate funds as grants to States based on the number of meals provided in each State the prior year. These grants would be tied to an index, which would most likely reflect inflation. Such an approach may be attractive to nutrition providers who could plan their budgets with more certainty regarding income.

There are several other issues pertaining to commodities that may be addressed in the coming year. Older adults can benefit from commodities through several programs administered by the USDA. In addition to benefits that older Americans receive through the commodities and cash which are given to nutrition providers on a per meal basis, commodities are distributed in bulk to individuals and food banks. It is possible that during 1987, the Congress will address the problems encountered by those working with all commodity programs serving the elderly. Issues include: Availability of information regarding the use of commodities, transportation and distribution, processing, commodity regulations, and coordination of Federal, State, and local interests.

3. Administration on Aging Draft Proposal

On September 16, 1986, the House Select Committee on Aging and its Subcommittee on Human Services held a joint hearing which was the direct result of an Administration on Aging draft titled: "Proposed Amendments for the 1987 Reauthorization of the Older Americans Act." The proposal, which many aging advocates considered a threat to the current OAA program approach, became the focal point of one of the first hearings concerned with OAA reauthorization because of three primary changes it proposed. The AoA, represented by its newly confirmed Commissioner on Aging, did not endorse the proposal, and stated that OMB and Secretary Bowen had not yet commented on its content. To date this position has evolved no further.

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[3] Federal Register, v. 50, no. 160, p. 33363.

A brief review of the three most controversial elements of the proposal follows: First, the document, if implemented, would change the formula used to allot funds to States for support and nutrition services. Under current law, the number of persons in a State aged 60 and older as compared to all States is used to distribute moneys. The AoA proposal would change the formula so that each State would receive its OAA dollars based on the number of persons 70 years and older living in that State as compared to all States. The hearing brought out substantial testimony in opposition to this change, primarily based on the concept that the act already is targeted to those with the greatest economic or social need. And that the proposal would allocate funds without regard for that need, but with regard to the less relevant issue of the number of persons age 70 or older living in a State. This change ignores the fact that many persons under age 60, particularly minority group members, need services and in some cases are less likely to live past age 70. There needs would not be considered with such a formula change.

The second issue is the plan to block grant the services under title III. Much of the opposition to this approach is rooted in the fear that nutrition programs will erode as dollars are shifted to services such as in-home care, which is in great demand. In addition, block granting of programs has often led to reductions in funding levels, making such proposals suspect to aging advocates.

The third concern lies in the proposal to permit the Commissioner on Aging to waive any requirement of title III if that waiver would result in greater flexibility and improved quality of efficiency in services designed to assist vulnerable older adults to regain or maintain their independence. This proposal created a strong concern that, in the name of efficiency, it could facilitate the end of many services important to older Americans. Testimony showed firm support for providing all mandated services in every community.

In conclusion, the AoA has to date not submitted this proposal or a modification of it to Congress. When they do, it will undergo further scrutiny by both the House and Senate committees concerned with aging issues.

4. WHITE HOUSE CONFERENCE ON AGING—1991

Another issue with which Congress must grapple during the OAA reauthorization process is the future of White House Conferences on Aging. Aging advocates in Washington began to meet to consider the possibilities for a 1991 Conference during the 99th Congress. The reactions to the thought of holding another White House conference seem to be mixed. One of the primary issues to be considered is whether or not a conference would attempt to be all-encompassing or focus on one or more key dilemmas that the aging population will face in the coming decades. For example, should the conference deal primarily with the issue of providing long-term care for the elderly?

In addition, how much money should be dedicated to a conference in light of the budget deficit and the increasing demand for OAA services? Also, how can aging advocates ensure that the conference will not be used to misrepresent the political positions of the administration and to manipulate older Americans and press opportunities? These questions and others will most probably be considered during this year's reauthorization because funding for a 1991 White House Conference on Aging will be incorporated in the bill.

5. Long-Term Care and the OAA

One issue that is bound to surface during the reauthorization process is how to focus more OAA resources on community-based long-term care services. And which community agency or service provider should have the responsibility to provide the necessary case management activities? Debate over the role that area agencies on aging play in case management will continue to cause some friction between OAA advocates.

In addition, the OAA ombudsman program, which is charged with investigating and resolving complaints made by or on behalf of elderly residents of nursing homes and other long-term care facilities is likely to be strengthened during the reauthorization process. Congress will need to sort through numerous bills and proposals that have been put forth during the last few years to improve the program.

6. Minority Elderly and the OAA

Recent criticism of the ability of the OAA to provide the needed services to many of the most needy minority older adults may help to focus the reauthorization process on the issue of minority group use of OAA funds. As mentioned earlier, there are advocates who believe strongly that the act should be better targeted to the most economically and socially needy older Americans. Declines in the number and proportion of older minority participants in OAA programs have caused concern and a desire to address this situation through legislative initiatives if possible.

Indian elders were the topic of two hearings during the 99th Congress conducted by the Senate Special Committee on Aging. Senator Nickles held a hearing in Oklahoma City which focused on the issue of access to services by older Indians, and the level of responsiveness to the title VI grantees by the Administration on Aging. The need for an Indian Desk at the AoA and the lack of availability of title III services for Indians was considered. Senator Bingaman held a hearing in Sante Fe titled "The Continuum of Health Care for Indian Elders." As the title suggests, the hearing covered a wide range of service delivery and availability issues. Witnesses revealed many of the gaps in crucial services which older Indians, often with few resources, must face. It is likely that legislative initiatives will result from these hearings, and that they may be incorporated in the reauthorization legislation this year.

In addition to the aformentioned issues, the upcoming 1987 reauthorization will probably encompass a review of many programmatic issues, including State and area agency on aging initiatives in community-based long-term care and new ways of handling the pressures created by the Medicare prospective reimbursement system. The case management systems (as defined in the 1984 reauthorization) will also be analyzed.

C. LEGISLATION

1. Commodities Program

On September 23, 1985, the House Education and Labor Committee reported H.R. 2453 to amend the U.S. Department of Agriculture [USDA] elderly commodity program authorized under section 311 of the act by increasing the authorization of appropriations for fiscal years 1985, 1986, and 1987 (H. Rept. 286). This bill passed the House on September 24, 1985. On November 19, 1985, Senator Grassley introduced S. 1858, also designed to increase the authorization of appropriations for these fiscal years. The bills were intended to remedy a potential shortfall in the authorized levels for these years.

To assure that States would receive reimbursement at the amount anticipated in February 1985, Congress enacted legislation (Public Law 99-269, signed April 1, 1986), to set the per meal reimbursement level at 56.76 cents and to increase the authorization levels. Public Law 99-269 set the authorization levels at $127.8 million for fiscal year 1985 and $144 million for each of fiscal years 1986 and 1987. In addition to the above amendments, Public Law 99-269 required the Secretary of Agriculture and the Secretary of Health and Human Services to inform State and area agencies and nutrition service grantees of their eligibility of participate in the National Commodity Processing Program.

In related action, two measures were enacted to appropriate additional funds for fiscal year 1986 to support the higher per meal reimbursement rates. The first action was taken in the fiscal year 1986 continuing resolution (Public Law 99-190) which appropriated $137.8 million for the elderly commodities program. The conference report on H.R. 3037, making fiscal year 1986 appropriations for the Department of Agriculture, Rural Development, and Related Agencies and which was incorporated by the continuing resolution, allowed up to $7 million of this amount to be used for meals served in fiscal year 1985. It is estimated that 225 million meals were served in fiscal year 1985. If States were to be reimbursed for the 225 million meals served in fiscal year 1985, at the reimbursement level of 56.76 cents per meal established by Public Law 99-269, approximately $7 million would be needed above the amount previously available in fiscal year 1985.

However, despite the language in the conference report on Public Law 99-190, on May 13, USDA indicated that it would not exercise its option to transfer $7 million of fiscal year 1986 funds to pay for the 225 million meals served in fiscal year 1985. USDA then set the fiscal year 1985 per meal reimbursement rate at 53.6 cents. (This meal rate was calculated by dividing the original fiscal year 1985 authorization level of $120.8 million by the 225 million meals served.) USDA indicated that since the funds available for fiscal year 1986 were not sufficient to reimburse for meals at the rate of 56.76 cents for both fiscal year 1985 and 1986, as called for by Public Law 99-269, to transfer funds from the 1986 appropriation to pay for meals served in fiscal year 1985 would create a shortfall of funds in fiscal year 1986.[4]

Since USDA did not take action to increase funding to pay for the excess meals served in 1985 as authorized in Public Law 99-190, Congress took subsequent action in another fiscal year 1986 appropriations measure. Congress approved as part of the fiscal year 1986 Urgent Supplemental Appropriations Bill (Public Law 99-349), $8.5 million in additional funds to support the full 56.76 cents per meal reimbursement level for both fiscal years 1985 and 1986 as authorized by Public Law 99-269. In a colloquy between Representatives Biaggi and Whitten discussing this provision in the conference report on H.R. 4515, Representative Biaggi indicated that the express purpose of the amendment is "to allow the reimbursement rate provided to States to be set at 56.76 cents made retroactive to fiscal year 1985 and throughout fiscal year 1986."[5]

In response to this legislation, USDA indicated in a hearing before the House Aging Committee on July 30, 1986, that it is setting aside $2.3 million of the $8.5 million made available by Public Law 99-349 to pay for fiscal year 1986 meals. Together with funds provided by fiscal year 1986 appropriations, USDA indicated that these funds will support 235 million meals at the 56.76 cents per meal rate. The balance of the funds provided by Public Law 99-349, $6.2 million, was to be made available immediately to States as additional reimbursement for fiscal year 1985 meals. USDA further indicated that once final meals counts for fiscal year 1986 are reported by States in January 1987 and final payments are made at the 56.76 cents rate for meals served in fiscal year 1986, any portion of the $2.3 million not needed for fiscal year 1986 payments will be used to make further reimbursements of fiscal year 1985 meals up to the 56.76 cents rate.

2. Older Americans Act Funding

For fiscal year 1987 the Reagan Administration budget proposed the same funding level as was originally appropriated for fiscal year 1986 for most Older Americans Act programs prior to the 4.3-percent reduction pursuant to the Gramm-Rudman-Hollings Act (Public Law 99-177). The presequestration fiscal year 1986 level for all programs was nearly $1.2 billion; sequestration cancelled $50 million of these funds. The administration proposed slightly more than $1.1 billion for the fiscal year 1987, however, for the title IV research, training, and demonstration program a reduction of $12.5 million was requested, a 50-percent reduction from the original 1986 level. For the USDA commodity program, the administration requested $132 million compared to $137.8 million appropriated (before sequestration and other reductions) for fiscal year 1986.

For fiscal year 1987 Congress provided $1.2 billion for all Older Americans Act programs as part of the fiscal year 1987 continuing appropriations (Public Law 99-500, H.J. Res. 738). Table 2 shows the fiscal year 1986 appropriations levels before and after sequestration, the President's fiscal year 1987 request, and the fiscal year 1987 appropriations.

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[4] Federal Register, v. 51, no. 106, June 3, 1986. p. 19880.

[5] Congressional Record, v. 132, June 24, 1986. p. H4116.

TABLE 11-2.—OLDER AMERICANS ACT—FISCAL YEAR 1986 FUNDING LEVEL, FISCAL YEAR 1987 ADMINISTRATION PROPOSALS AND APPROPRIATIONS

[In thousands of dollars]

	Fiscal year 1985		Fiscal year 1987	
	Appropriation	After sequest.	Administration proposal	Appropriations
Title II: Federal Council on Aging	$200	$191	$200	$200
Title III:				
Supportive services and senior centers	265,00	253,000	256,000	270,000
Nutrition services:				
Congregate	336,000	[1] 321,522	336,00	348,000
Home-delivered	67,900	64,980	67,900	74,000
USDA commodities	137,00	[2] 133,383	132,000	137,157
Subtotal, title III	806,700	773,490	800,900	829,157
Title IV Training, research and discretionary projects and programs	25,000	[3] 23,925	12,500	25,000
Title V: Community service employment	326,000	[4] 312,002	326,000	326,000
Title VI: Grants for Indian tribes	7,500	7,178	7,500	7,500
Title VII: Older Americans Personal Health Education and Training Program	0	0	0	0
Total	1,165,400	1,116,786	1,147,100	1,187,857

[1] This amount also reflects $30,000 withheld in fiscal year 1986 in accordance with Section 515 of Public Law 99-190 related to consulting, management services and technical assistance.

[2] This amount reflects the 4.3 percent reduction required by the Gramm-Rudman-Hollings Act and a 0.6 percent reduction allowed by the Appropriation legislation. It also reflects supplemental funds added by Public Law 99-349, fiscal year 1986 Urgent Supplemental appropriations. This legislation added $8.5 million to support the elderly commodity program; this amount was intended to support the program at the 56.76 cents per meal reimbursement level for both fiscal year 1985 and fiscal year 1986. USDA set aside $6.2 million of the $8.5 million to support fiscal year 1985 meals and $2.3 million to support fiscal year 1986 meals. The fiscal year 1986 amount available prior to enactment of Public Law 99-349 was $131,083,000. See text.

[3] The Administration requested a $11,425,000 rescission from the amount shown.

[4] The amount available in fiscal year 1986 was previously reduced by an additional $471,000 withheld from the Trust Territories pursuant to the Compact of Free Association. This amount was recently restored bringing the total available to the amount shown.

Source: Congressional Research Service, October 1986.

D. PROGNOSIS

Fiscal year 1986 marked the 21st anniversary of the Older Americans Act. With the exception of some 1981-82 program reductions, the act has consistently received increased appropriations despite the Reagan Administration's efforts to substantially reduce domestic spending.

The future funding of the Older Americans Act remains promising even in light of the Federal Government's current financial crisis and the corresponding budget-cutting mood in Congress. Although, the Title VII, Older Americans Personal Health Education and Training Program, has not been funded, the title III programs continue to receive small increases in appropriations. As appropriation levels continue to be high percentages of authorization levels, and 1987 brings a focus to the act's excellent accomplishments, it is very likely that reauthorization will expand the already broad-based support for the OAA. It will also give Congress a chance to put its money where its rhetoric is by increasing funding levels once again.

It is possible that many domestic programs will be further reduced between fiscal years 1988 and 1990, but the OAA appears to be safe at this time. If cuts were to be imposed, they would result in the provision of fewer services to the most rapidly growing segment of our population. Such cuts would magnify the claim by some that it is necessary to develop new ways to better focus resources while maintaining the integrity of the OAA approach.

The 100th Congress will almost certainly reauthorize the OAA during the first session. Several reauthorization hearings already took place during the 99th Congress, including a hearing conducted by the Senate Aging Subcommittee of Labor and Human Resources. That hearing, held on August 2, 1986, was designed to identify the main issues on which Congress should focus, and to measure the need for wide-ranging versus fine-tuning changes in the act. The type or scope of changes remain the major question for this year's reauthorization. The process, which could be over as early as late May, could be very exciting if the issues of targeting, use of commodities, the AoA proposal, and minority access to services are seriously considered, or it could be almost a formality if advocates and Congress feel content with the program's status quo.

In sum, the Older Americans Act, which has truly become a major social service initiative, has fared well during the past 11 years, and will continue to do so whether major modifications or fine-tuning proposals are adopted during its reauthorization process this year.

Chapter 12

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, and volunteer opportunities for older Americans.

During the Reagan Administration, two basic themes have emerged with respect to the delivery of social services for the elderly. First, the administration has sought to give States greater discretion in the administration of social services as part of its "New Federalism" initiatives. Second, the shift toward block grant funding has been accompanied by a general trend toward fiscal restraint and retrenchment. As a result, the competition for scarce resources has been accelerated between the elderly and other needy groups. In addition to the cuts accompanying the block grants, the administration has proposed to reduce spending for education, transportation, and legal services. Fiscal restraint in these programs has affected service delivery in varying degrees, with the most significant cuts coming in legal services, which the administration has sought to eliminate entirely. Older American Volunteer Programs [OAVP], in contrast, have enjoyed strong support from the administration.

For the most part, Congress has resisted the administration's efforts to reduce funding for social, community, and legal services. Following the cuts sustained in the fiscal year 1981 budget, Congress increased spending for the Social Services Block Grant [SSBG], and the Community Services Block Grant [CSBG], and legal services, and in fiscal year 1985, increased significantly authorized spending levels for adult education and other education programs benefiting the elderly. The focus on Federal spending, however, is not clearly framed by the widespread concern over budget deficits. Advocates of human service programs are hopeful that the new Senate majority will be able to direct more resources toward social service programs. The likelihood of this is unclear considering the limitations created by the Gramm-Rudman-Hollings legislation and an apparently strong desire to avoid initiating tax increases. The resolution of this debate may very well determine the Federal role in providing social services to the elderly in the years ahead.

A. BLOCK GRANTS

1. BACKGROUND

(A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-dollar match of State social services funding. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration.

Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded and certain day care services which received 100 percent Federal funds. Training was also matched at a 75 percent Federal rate. Significantly, the law required that at least half of each State's Federal allotment be used for services to recipients of Aid to Families with Dependent Childern [AFDC], Supplemental Security Income [SSI], or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 and 115 percent of the State median income. States also were required to follow a specified planning and public participation process.

In 1981, Congress created the social services block grant [SSBG] as part of the Omnibus Budget Reconciliation Act. By elimination most of the restrictions in title XX, Congress granted the Reagan Administration added flexibility to transfer maximum decision-making authority to the States. Under the SSBG, States are no longer required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated, and Federal standards for services, particularly for child day care, also were dropped. The SSBG's allow States to design their own mix of services and to establish their own eligibility requirements.

(B) COMMUNITY SERVICE BLOCK GRANT

The community services block grant [CSBG] is the current version of the Community Action Program [CAP], which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity [OEO], a component of the Executive Office of the President. In 1975, OEO was renamed the Community Services Administration (CSA) and reestablished as an independent, executive branch agency.

As the cornerstone of OEO/CSA antiproverty activities, the Community Action Program gave basic seed grants to local, private, nonprofit or public organizations designated as the official antipoverty agency for a community. These community action agencies [CAA's] were directed to provide services and activities "having a measurable and potentially major" impact on the causes of poverty. During the 17-year history of OEO/CSA, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low-income energy assistance, and weatherization. The OEO budget peaked in fiscal year 1969 and 1970 with an annual funding of $1.9 billion. The funding then steadily declined until CSA's last year of existence in fiscal year 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. CSA programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at the State level and at the point of delivery.

2. Issues

(A) NEED FOR CSBG

In 1981, the Reagan Administration proposed elimination of CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and Congressional Oversight Committee had criticized CSA as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress, in the Omnibus Reconciliation Act of 1981, abolished CSA as a separate agency but replaced it with the community services block grant [CSBG] to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

The CSBG act requires States to submit an application to the DHHS, assuring that they will comply with certain requirements, and a plan showing how these assurances will be carried out. States must guarantee that the State legislature will hold hearings on the use of funds each year. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs, and to encourage the use of private sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Head Start, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Funding for the new block grant in fiscal year 1982 amounted to a 30-percent reduction from CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of CSA.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act offered States the option of not administering the new CSBG during fiscal year 1982. Instead, DHHS would continue to fund the existing CSA grantees in those States until States themselves were ready to take over the program. States which did not opt to administer the block grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior CSA grantees. In the act, this 90 percent passthrough requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision for CAA's and former CSA grantees in order to ensure program continuity and viability. The extension is viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they administer. Four States, Wyoming, Utah, Nevada, and Colorado qualified for an exemption because a significant portion of their counties were not served by an existing CAA. Congress, in 1984, made the 90 percent pass-through requirement permanent and applicable to all States, under Public Law 98-558.

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG suggested fewer restrictions. According to the administration, States would then be able to develop the mix of services and activities which were most appropriate to the unique social and economic needs of their residents. Congress, however, has continued to resist the administration's proposal and has continued to support funding for the CSBG, which would be blunted by incorporation into the SSBG.

(B) ELDERLY SHARE OF SERVICES

The role that the social services block grant plays in providing services to the elderly has been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for vulnerable groups, including the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

The extent of program participation on the part of the elderly under title XX was difficult to determine because programs were under the program, and as a result, it was difficult to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under the social services block grant has made efforts to track services to the elderly even more difficult.

It is equally difficult to determine the degree to which SSBG dollars benefit the elderly. Based on the limited data that was available, the Office of Management and Budget estimated in 1981 that some 21 percent of the total title XX dollars went to services for the elderly. The National Data Base on Aging reported that SSBG funds comprised approximately 6.3 percent of State units on aging budgets and 4 percent of area agencies on aging budgets in 1982.

In addition to problems in determining funding amounts, little data exists on the national level indicating the extent to which SSBG programs are actually coordinated with other programs, or the extent to which services overlap.

The implications of a GAO study on SSBG services for the elderly are unclear due to the lack of programmatic data on State expenditures. GAO did report that funding for home-based services, which includes trained homemaker services, home maintenance and personal care services, home management services, and home health aid services, fluctuated among the States between 1981 and 1983. Some States reduced funding for these services by simply shifting program support to Medicaid. Florida, for example, chose to target their block grant dollars to disabled adults between the ages of 18 and 59, where previously, the State focused on all elderly and disabled persons. At the other end of the spectrum, Pennsylvania increased their emphasis on home-based services for the elderly as a means of preventing more costly institutionalization.

It seems clear that while funding for the SSBG has remained relatively constant, the potential for fierce competition among recipient groups is strongly indicated. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interest of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments, as policymakers contend with issues of access and equity in the allocation of scarce resources. A voluntary survey conducted by the American Public Welfare Association [APWA] found that in 21 States, people age 60 and older made up 15 percent of SSBG recipients in fiscal year 1983. Comparing 12 of these States with data from the same States in fiscal year 1982, APWA found that the same percentage of elderly recipients in these States dropped from 19.1 percent in fiscal year 1982 to 14.7 percent in fiscal year 1983. At the same time, the number of children recipients rose from 38.8 percent in fiscal year 1982 to 46.4 percent in fiscal year 1983.

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of block grant funds.

A 1984 study by the National Governors Association [NGA] on State use of fiscal year 1983 CSBG funds does provide some interesting clues, however. NGA found that CSBG's 90 percent pass-through requirement to CAA's effectively limited States' discretionary spending. Out of the more than 900 CAA's which had existed in 1981, 861 CAA's were receiving CSBG funds in fiscal year 1983. With respect of funding formulas, States allot funds based on any of the following: The amount received from CSA in fiscal year 1981; a straight formula based on the number of poor people in the communities served by the grantee; a minimum funding level plus an additional amount based on a poverty level. Most importantly, NGA received data on CSBG expenditures broken down by program category and number of persons served which provides some indication of the impact of CSBG services on the elderly (see table 12–1). For example, expenditures for employment services, which includes job training and referral services for the elderly, accounted for almost 13 percent of total expenditures and served over 400,000 persons. Housing programs, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, served over 765,000 persons in fiscal year 1983, many of whom are elderly. A catchall program category supported a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, and information and referrals or linkages with other programs. Emergency services such as donations of clothing, food and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds. Combined, these programs reached over 10 million needy persons in 1983. Unfortunately, data related to the age, sex, race, and income levels of program participants was not reported in the NGA survey. Until such data is analyzed, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

TABLE 12–1.—FISCAL 1983 CSBG EXPENDITURES AND PERSONS SERVED IN 34 STATES BY PROGRAM CATEGORY (SECTION D)

Program category	CSBG expenditure	Number of persons served
Employment	$25,189,314	433,141
In percent	12.8	1.6
Education	$11,540,553	3,456,287
In percent	5.9	12.9
Housing	$15,302,317	765,413
In percent	78.8	2.9
Better use of available income	$15,596,558	2,069,041
In percent	7.9	7.7
Emergency assistance	$20,435,408	2,408,978
In percent	10.4	9.0
Nutrition	$28,891,367	9,979,727
In percent	14.7	37.3
Linkages with other programs	$80,036,612	7,612,167

TABLE 12-1.—FISCAL 1983 CSBG EXPENDITURES AND PERSONS SERVED IN 34 STATES BY PROGRAM CATEGORY (SECTION D)—Continued

Program category	CSBG expenditure	Number of persons served
In percent	40.6	28.5
Total	$196,992,129	26,724,753
Total percent	100	100

(C) EFFECT OF BLOCK GRANTS ON FUNDING AND PRIORITIES

The implementation of the SSBG was accompanied by reduced Federal funding. However, in recent years funding levels have been increased slightly. In fiscal year 1982, the national title XX appropriation was $2.4 billion, compared to $2.991 billion in fiscal year 1981—a decrease of 20 percent. Funding for fiscal year 1983 was $2.45 billion from SSBG plus an additional $225 million appropriated through the emergency jobs bill legislation.

The reduction in Federal funding for social services which accompanied implementation of the block grant increased pressure on State and local governments and service providers to maintain program delivery. In response to concern that certain groups, including the elderly, would suffer a reduction in services under the block grant, Congress ordered the General Accounting Office [GAO] to assess the implementation and administration of the new SSBG, and the effect of reduced Federal funding on program priorities. The GAO report was released in August 1984. Although Federal support decreased as States began implementing the SSBG, the GAO found that most States increased their total social services expenditures between 1981 and 1983. This increase was accomplished primarily through increased State and other non-Federal funding as well as transfers from the other Federal block grant programs, such as the low-income home energy assistance block grant. This growth in expenditures, however, rarely kept pace with the increase in inflation during this period. These findings were similar to those of an Urban Institute study, released in 1985, which reviewed block grant spending patterns through 1984.

Generally, service areas funded under title XX continued to receive support in 1983 under the SSBG as States attempted to maintain program continuity. However, the reduced SSBG allocations caused States to reorder the priorities of individual service areas, reduce or eliminate services, and alter client eligibility criteria. GAO reported that States gave higher priority to adult and child protective services, adoption and foster care, home-based services, and family planning. The Urban Institute also found States have tended to shift their priorities toward crisis intervention services and protective services. The GAO report also offered insight for better understanding the political debate over the block grant approach. The majority of State officials view the block grants program as more flexible and less burdensome than prior programs. The majority of interest group representatives, however, believe that the block grant has resulted in a decrease in funding for social services and has had a generally negative impact on the interests of the groups they represent. While interest groups and State officials had differing views on the desirability of the block grant, both expressed concern about the Federal funding reductions that accompanied the block grant. Notably, many States believe that the advantages of the SSBG are diminished by reduced Federal funding, and that additional program discretion may be hampered by fiscal constraints imposed by the Federal Government.

Questions also remain regarding the effect of the CSBG program on the range and quality of services delivered in the community. When Congress shifted the primary administrative responsibility of numerous CSA categorical programs to the States under the CSBG, States' discretionary authority dramatically expanded over their prior limited involvement in community action program activities. Under both the OEO and CSA, almost all community service grants were made directly to local providers. States' roles were essentially to provide liaison activities and other support functions, usually through grants to State and economic opportunity offices. Few States had State-supported community services programs. Consequently, most States had no existing framework for planning community services. Given the States' limited experience in this area, and the reduction in Federal funding which accompanied the block grant, critics of the CSBG approach predicted adverse effects on program implementation and service delivery.

During 1982 and 1983, the General Accounting Office surveyed several States to assess the implementation and administration of the new CSBG, and the effect of reduced Federal funding on program delivery. The GAO report was released in September 1984. The report found the substantial decline in Federal funding, which was not offset by the infusion of State funds, created numerous changes in CAA support. The majority of CAA's sustained substantial funding reductions. Many providers have taken steps to compensate for reduced funds, such as charging fees, soliciting private contributions, seeking other Federal funding sources, and increasing the use of volunteers. The majority of providers, however, have reduced or eliminated services. Similar findings were reported by the Urban Institute in 1985. They found that States generally had not attempted to replace lost Federal dollars with their own funds.

Several conclusions can be drawn from the GAO study. In general, States have not taken advantage of the expanded authority under the CSBG to make substantial programmatic changes. Instead, States have carried out their block grant management responsibilities by establishing program requirements, monitoring service providers, providing technical assistance, collecting data, and arranging for audits. However, the States' level of involvement in setting program priorities may increase as State administrative units acquire additional experience and knowledge of community service needs. The escalating demand for scarce community service dollars and the corresponding political pressure from interest groups, in turn, may threaten to splinter community action programs into disjointed and ineffective parts. Consequently, this shift in program discretion from the CAA's to centralized State units will require more thoughtful public discourse on the assignment of service priorities in order to ensure an equitable distribution of service under the block grant.

The Urban Institute found that, to the extent possible within the constraints of the 90 percent passthrough requirement, States have shifted funds away from large urban community action agencies and have attempted to fund new agencies not previously financed under the Community Services Administration.

3. LEGISLATION

(A) SSBG APPROPRIATIONS

The 1981 Budget Reconciliation Act fixed authorization levels at 20 percent below fiscal year 1981 levels with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

For fiscal year 1986, President Reagan requested that the full entitlement level of $2.7 billion be appropriated for the SSBG, and Congress again appropriated that amount. However, under the Gramm-Rudman-Hollings deficit reduction procedures, $116 million was rescinded through automatic sequestration. Although the Supreme Court invalidated the process, Congress upheld the budget cuts in March 1986 with Public Law 99-366.

The President requested $2.7 billion for the SSBG for fiscal year 1987, as well. Both the Senate and House included this amount in the fiscal year 1987 budget resolution that they passed. Subsequently, Congress incorporated the $2.7 billion into a governmentwide continuing appropriations resolution for fiscal year 1987 (Public Law 99-500).

(B) CSBG REAUTHORIZATION AND APPROPRIATIONS

As established in the 1981 Omnibus Budget Reconciliation Act, the CSBG was scheduled to expire at the end of fiscal year 1986. Legislation to reauthorize CSBG as well as the Head Start Program and the Low-Income Energy Assistance Program through 1987 (S. 2565), was approved by the Senate Labor and Human Resources Committee on May 9, 1984.

An amended version of S. 2565, which did not extend CSBG beyond its 1986 expiration date but increased authorization levels for spending in fiscal years 1985 and 1986, passed the Senate by a voice vote on October 4 and was passed by the House on October 9. President Reagan signed the measure on November 1, 1984 (Public Law 98-558). This final version of the legislation also extended or amended Head Start, Follow Through, several higher education programs, Low-Income Weatherization, the Low-Income Home Energy Assistance Program, and Native American Programs.

Therefore, it was still necessary to reauthorize the community services block grant and discretionary activities in fiscal year 1987. The House and the Senate both passed legislation to extend the program through fiscal year 1990. The House bill (H.R. 4421) would have authorized $390 million for fiscal year 1987 and such sums as necessary for fiscal years 1988–90 for the CSBG program. (The previous law authorized $415 million for fiscal year 1986.) The Senate bill, S. 2444, would have reauthorized the program at $381.409 million for fiscal year 1987, $392.851 million for fiscal year 1988, $404.636 million for fiscal year 1989, and $416.775 million for fiscal year 1990.

The conference version of H.R. 4421 was signed into law (Public Law 99–425) on September 30, 1986, and extends the program through fiscal year 1990 at the following levels: $390 million in fiscal year 1987; $409.5 in fiscal year 1988; $430 million in fiscal year 1989; and $451.5 million in fiscal year 1990. The law also includes the Senate provisions expanding the definition of an eligible entity and establishing procedures for the review of State decisions to terminate funding for community action agencies or migrant and seasonal farmworker programs. Senate provisions relating to program evaluations are also included in the final law. The law also authorizes $3 million annually through fiscal year 1990 for the Community Food and Nutrition Program, and authorizes an additional $5 million annually, through fiscal year 1989, for a demonstration program of innovative antipoverty approaches.

As a result of the Gramm-Rudman-Hollings deficit reduction legislation, the $370.3 million which Congress appropriated for fiscal year 1986 was reduced to $354.4 million. Although the Supreme Court invalidated the automatic sequestration process, Congress upheld the cuts through enactment of Public Law 99–366 in March 1986.

The administration has submitted similar budget requests for the CSBG for several years. They proposed to phase out the CSBG during fiscal year 1986 and eliminate it entirely by fiscal year 1987. Only $3.6 million was requested for fiscal year 1987 to cover Federal administrative expenses related to the phasing out of the program. In addition, they requested a rescission of $182 million in fiscal year 1986 CSBG funds, which Congress did not allow.

One of the administration's primary contentions is that the CSBG program duplicates other Federal activities and is nonessential. This, however, runs contrary to the testimony made by the General Accounting Office before the House Education and Labor Committee in February 1986. GAO found from their analysis of visits to 16 community action agencies in eight States, that, in most cases, services supported by the CSBG do not duplicate activities provided by local social services agencies. CSBG funds are often used to fill specific unmet needs or to provide services not eligible for funding under the SSBG.

Nevertheless, neither the fiscal year 1987 budget resolution passed by the House and the Senate, nor the conference report, mentioned the CSBG. Materials prepared by Senate Budget Committee staff did mention the program and a conference agreement to reduce it by 10 percent.

Subsequently, the House provided no funding in H.R. 5233, a fiscal year 1987 appropriations bill for HHS, because the program had not been reauthorized at the time. The Senate, however, provided $378.9 million for the CSBG and $2.5 million for the Community Food and Nutrition Program. In conference, Congress provided

$369.9 million for the CSBG, and $2.5 for the Community Food and Nutrition Program. Although this legislation was never enacted, its provisions for CSBG were included in the governmentwide continuing resolution (Public Law 99-500).

B. HOMELESS SERVICES

1. Issues

(A) NEED

Over the past few years, the plight of the Nation's homeless and hungry has attracted a great deal of concern and publicity. Homeless persons are those who lack permanent residence and spend the nights in shelters, on the streets or in other makeshift arrangements. Although reliable statistics are hard to find, it is clear that an enormous number of Americans are homeless—probably between 250,000 and 3 million. The Department of Housing and Urban Development unleashed a storm of controversy with a May 1984 report that concluded that there were only 250,000 to 350,000 homeless persons nationwide. Other groups that help the homeless insist that the total is about 10 times that amount.

Two hearings dedicated solely to an investigation of the HUD report were held in Congress in 1984 and 1985. A study completed in 1986 by the National Bureau of Economic Research [NBER] upheld the conclusion of the HUD study regarding the approximate size of the homeless population in 1983. The NBER study also concludes, however, that the homeless population increased by 23 to 30 percent from 1983 to 1985. While questions may be raised concerning the methodology of the report, comparative data to verify or challenge the NBER study are not readily available.

While no one knows precisely how many Americans are going hungry or are malnourished, institutions involved in providing emergency food assistance have seen dramatic increases in the numbers of people seeking food assistance during the past few years. According to a report released in January 1986 by the U.S. Conference of Mayors, hunger and homelessness rose sharply (28 percent and 25 percent, respectively) in the 25 urban areas surveyed in 1985.

In April 1985, the General Accounting Office released a report on homelessness showing that there was widespread agreement that homelessness is increasing. GAO found that while a reduction in the unemployment rate may help to reduce the number of homeless, deinstitutionalization of mentally ill persons and a continuing decline in low-income housing and public assistance programs may be offsetting any effect on the overall number of homeless persons. A May 1986 report by the Partnership for the Homeless entitled, "National Growth in Homelessness: Winter 1986 and Beyond," found: That homelessness substantially increased again in the winter of 1985 (16 percent), while the number of homeless who could not be provided shelter also increased (12.9 percent); that the number of homeless families with children continued to increase more rapidly than the number of homeless single adults and youths; and that most of the Nation's major cities have not planned to cushion the impact of expected Federal budget cuts in programs for the homeless. The NBER study also found that homelessness is a long-term state with causes going far beyond the recent economic recession and that if changes in the distribution of income and in the housing market continue, the at-risk population is likely to grow rather than decline.

Homelessness stems from a variety of factors: Unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, and housing shortfalls in urban areas. The deinstitutionalized chronically mentally ill comprise the most substantial portion of the homeless—about one-third of the total. According to the administration's Interagency Task Force on Food and Shelter for the Homeless, the number of patients in mental hospitals decreased from 505,000 in 1963 to 125,000 in 1981, In some cities, veterans of Vietnam or earlier conflicts are thought to make up one-third to one-half of the homeless. The fastest growing group among the homeless, however, is unemployed individuals and their families. The 1986 U.S. Conference of Mayor's report states that 60 percent of the homeless are single men, 12 percent are single women, and 27 percent are families with children. The cities reported an 85-percent increase in homeless children, reflecting a trend that began with the recession. Recent studies have also documented a new dimension—the suburban homeless. According to reports, in some relatively affluent suburban communities with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses, and instead, are living on the streets, in publicly funded shelters, or in their automobiles.

For the elderly who are homeless, a great deal of the problem results from the lack of health care and affordable housing due to skyrocketing rents, elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. The Reagan Administration has, for example, stopped new construction of low-income housing, while cutting annual Federal subsidies. In the meantime, the number of people on waiting lists for low-income public housing has burgeoned.

For the mentally disabled, the policy of deinstitutionalization has led to the emptying of State hospitals, but with no intermediate community services other than community mental health centers. Many believe that these centers are underfunded, uncoordinated, and don't address the shelter needs of the chronically mentally ill in a significant way. Unfortunately, the homeless must negotiate their way through a fragmented, complicated, and often hostile system of income, housing, health and social service agencies and programs.

(B) SERVICES

Private and public resource have been mobilized to attempt to meet the immediate needs for food and shelter. Shelters and other facilities available to the homeless are generally provided by private groups, sometimes with financial help from a local government. In addition to emergency shelters, some localities provide families or individuals with certificates or vouchers to help pay the rent and thus avoid eviction and homelessness. Vouchers may also be given to destitute people to enable them to rent rooms in single-room occupancy buildings or hotels.

Something of a new frontier in the law has recently begun to develop in the realm of rights of homeless individuals. As reported by the New York Times in July 1986, in the face of housing shortages, homeless people are increasingly turning to the courts for assistance and judges have started to define their rights. While the Constitution does not explicitly guarantee a right to shelter, judges have ordered State and local officials to provide shelter based on State constitutions and statutes and on provisions in the Federal laws. In this vein, in July 1986, the Homelessness Task Force prepared a litigation memorandum entitled "Homelessness in America," which describes litigation that has been brought to address problems of homeless people and current case law. It can be expected that advocates for the politically powerless homeless will continue to use the courts to obtain and to enforce the basic rights and benefits of the homeless.

The Emergency Food and Shelter Program, currently administered by the Federal Emergency Management Agency [FEMA], has provided over $370 million for food, shelter, and other forms of assistance to the homeless. The program was initiated in the Emergency Jobs Appropriations Act approved in March 1983 (Public Law 98-8), and has continued through appropriations, supplemental appropriations, and a continuing resolution in subsequent years. Originally, funds for the program were disbursed through two channels. One was through a national board composed of representatives from six charitable organizations and from FEMA itself. The other was through the States to whom FEMA was authorized to distribute $50 million for further allocation to local distributors and service agencies. The State channel was subsequently eliminated.

Delays in the State channel seem to have caused its elimination. In an evaluation of the shelter program, in 1985, the Urban Institute noted the speed and flexibility with which the national board and the nonprofit sector were able to get money for emergency food and shelter to the local communities. According to the Urban Institute, delays in the State channel resulted from lack of State authorizing legislation, State requirements for written regulations, State requirements for proposal and assessment processes, obligations without distribution, and time lags because of State coordination requirements.

By most accounts, the FEMA program, which has utilized local programs rather than duplicating their efforts by applying a new layer of bureaucracy, has worked well. In 1985, the FEMA program funded about 51 million meals at a cost of $36.8 million. On average, a meal provided from these funds cost less than 75 cents; a night in a shelter cost less than $3.

Hundreds of citizens have also voluntarily donated time and money to help feed the hungry and house the homeless. But even with these efforts, optimistic statistics show that only 1 in 3 homeless individuals had a bed and a bowl of soup in a public or private shelter in the winter of 1985. Other figures suggest that only 1 out of every 20 were so fortunate. Both figures illustrate how much is yet to be done. The HUD report, for example, states that in 1984 there were about 111,000 shelther spaces available nationwide for as many as 350,000 homeless, indicating a serious capacity shortage. These shelters, moreover, are at risk in many communities because of neighborhood opposition, inner-city redevelopment, and other factors. More recently, the U.S. Conference of Mayors reported that, in half of the 25 cities they surveyed, homeless people are "routinely" turned away from overcrowed shelters and 17 percent of the demand for emergency food goes unmet.

(C) FEDERAL ROLE

The Reagan Administration contends that homelessness is a local problem and maintains that the Federal role should be limited to making available, to the homeless, surplus resources, such as food and buildings. In his 1986 budget request, President Reagan proposed continuing the Interagency Task Force on Food and Shelter for the Homeless, which coordinates administration efforts to aid the homeless. The 1987 budget request, however, did not contain a reference to the task force. As in previous years, the administration wanted to eliminate the program of the Federal Emergency Management Agency [FEMA] that has provided emergency funding for food and shelter for the homeless over the past 4 years. The President also called for cuts in block grants for community services and development that have been used by some States and localities to provide food and shelter to homeless individuals. In addition, the administration wanted to eliminate TEFAP, the emergency feeding program within the Department of Agriculture.

The administration's task force was created in October 1983 and was charged with coordinating Federal efforts to help the homeless by identifying potential resources controlled by Federal agencies and by cutting bureaucratic redtape to make the resources available to the homeless. By late 1984, the task force had reportedly reached agreements with the General Services Administration and the Departments of Defense, Housing and Urban Development, Transportation, and Agriculture to lease surplus facilities to be used as homeless shelters, or to make food donations to the shelters. According to the Congressional Quarterly, however, no figures were available on the anticipated numbers of beds or the amounts of food and other aid likely to be provided. Critics of the task force charge that little surplus food and shelter have materialized and argue that Federal agencies have been uncooperative in providing aid to the homeless. The efforts of the task force were sharply criticized by the House Government Operations Subcommittee on Intergovernmental Relations and Human Resources.

In December 1983, the Counselor to the President, spurred a controversy over the issue of the homeless when he said, "I think some people are going to soup kitchens voluntarily. I know we've had considerable information that people go to soup kitchens because the food is free and that's easier than paying for it." In January 1984, President Reagan said that he thought some of the homeless people sleeping on grates in cities were doing so "by choice." And in February 1986, the Director of the Office of Management and Budget said that the homeless of America were a problem to be solved by State and local governments, not by the Federal Government. Unfortunately, according to a New York Times/CBS News Poll conducted in January 1986, about half of all adult Americans think local governments are not demonstrating enough concern for the homeless. This may also indicate that both the Federal and State governments are not meeting their obligations toward the homeless.

2. LEGISLATION

As previously mentioned, the primary response of the Federal Government to the problem of homelessness in the Nation has been through the Emergency Food and Shelter Program administered by FEMA. In June 1985, the Senate passed an amendment to the second supplemental appropriations bill (H.R. 2577), sponsored by Senator Dixon and Senator Heinz, appropriating $110 million for the homeless through 1986. Subsequently, the conference committee recommended that $20 million be appropriated for the remainder of 1985 and that any funds for 1986 be included in the 1986 HUD-independent agencies appropriations bill. The House then included $70 million for fiscal year 1986 for the homeless, but the Senate Appropriations Committee cut this back to $50 million in mark-up.

On October 17, 1985, Senators Dixon and Heinz, successfully introduced an amendment to H.R. 3038, the HUD-independent agencies appropriations bill, adding $20 million to the Senate version of the bill, to bring it in line with the House-passed version, which contained $70 million for the homeless for fiscal year 1986. On the same day, the Senate unanimously accepted a second degree amendment to the Dixon-Heinz amendment, which would have established a permanent homeless program, by transferring the FEMA program to the Department of Housing and Urban Development [HUD] and authorizing the program for 3 years. While the $70 million appropriation for the FEMA homeless program was accepted in conference, the homeless housing assistance amendment was deleted.

The most recent funding, $70 million, originated in the House of Representatives in H.R. 5313, the HUD-Independent Agencies Appropriation Act for fiscal year 1987, and was agreed to in conference and incorporated in the fiscal year 1987 continuing resolution (Public Law 99-500). Included in the continuing resolution is a transitional program, adopted as Title V of the HUD-Independent Agencies Appropriation Act for fiscal year 1987 with an additional appropriation of $15 million. The program is intended "to develop innovative approaches for providing transitional housing and supportive services for homeless persons, focusing on those capable of moving into independent living". The funds may be used by applicants to acquire, rehabilitate, or lease existing structures and to pay for a share of the operating costs associated with using the structures for the homeless. In the Senate, the new program had originally been proposed by Senators Heinz, Gorton, and Dixon.

Many homeless qualify for public assistance, but are unaware of the programs, lack the skills to obtain benefits, or are unable to apply because they have no address. Some, for example qualify for Supplemental Security Income [SSI], which provides aid to the needy blind, disabled, and elderly. Others qualify for other benefits, such as food stamps and veteran's benefits. In the 99th Congress, statutes governing various walfare programs were amended to provide for the needs of the homeless through amendments included in the Homeless Eligibility Clarification Act (Title XI of the Anti-Drug Abuse Act of 1986, Public Law 99-570). In brief, the law will:

(1) remove restrictions which limited food stamp eligibility of homeless persons living in shelters;

(2) authorize homeless persons, at their option, to use food stamps for meals served in shelters, soup kitchens, and other agencies;

(3) require States to specify plans for coordinating the Job Training Partnership Act [JTPA] program with other programs which aid the homeless;

(4) add homeless persons to the categories that may be served by State-administered JTPA special services programs as well as to categories of persons eligible for JTPA assistance even though their income exceeds the JTPA eligibility limit;

(5) require that Supplemental Security Income [SSI] payments be made to eligible homeless persons;

(6) direct States to provide a method for issuing Medicaid eligibility cards to eligible homeless persons;

(7) require the establishment of Federal guidelines for the provision of Aid to Families with Dependent Children [AFDC] to the homeless;

(8) mandate a system to enable persons to apply for SSI and food stamp benefits prior to release from a public institution;

(9) stipulate that the Veterans Administration could not deny veterans benefits because an applicant lacked a mailing address; and

(10) require the U.S. Veterans Administration to establish methods of delivering veterans' benefits to persons lacking a mailing address.

In addition, the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) included language which prohibited States from denying Medicaid eligibility to a person because the applicant lacked a permanent residence or fixed address.

In addition to existing State block grants that allow funds to be spent for the homeless, the Federal Government provided special assistance through the Temporary Emergency Food Assistance Program [TEFAP], which provides funds for costs associated with the provision of commodities to low-income persons through soup kitchens and other organizations. Food valued at $978 million was distributed in 1985.

In the Food Security Act of 1985 (Public Law 99-198), Congress extended the authorization for the TEFAP through fiscal year 1987, authorized $50 million per year in Federal appropriations for transportation and storage costs incurred by State and local agencies administering TEFAP, and required that States match, dollar for dollar (in cash or in kind) the Federal contribution for transportation and storage costs, beginning in January 1987.

A variety of categorical aids and block grants are available through the Departments of Health and Human Services [HHS], Labor, and Education, and ACTION. The Social Services Block Grants, an HHS program enables States to provide a mix of services including short term shelter, legal services, and foster care. The President requested $2.7 billion for this program in his 1987 budget, approximately the same level as in 1985 and 1986. The Community Services Block Grants, also administered by HHS, are made to States for the purpose of alleviating causes of poverty. The States, in turn, channel funds to local community action agencies or similar organizations to carry out antipoverty programs. The administration has been trying for several years to phase out these programs. Unfortunately, it is not known how many homeless persons actually receive benefits under these programs.

3. PROGNOSIS

Most Members of Congress believe that solutions to the problem of homelessness should be developed at the local level. Unlike the administration, however, they feel that the Federal Government has an important role to play in the solution. In 1986, Congress chose to continue to fund the FEMA program on an ad hoc basis, as it has done in the past. It took, however, a limited step toward providing lasting solutions for the range of problems facing the homeless by the creation of a transitional demonstration program.

It is clear, however, that more long-term solutions to the problems of homelessness are needed. The focus is now on efforts that go beyond emergency food and shelter services to attempt to deal with the underlying causes of long-term homelessness, such as lack of job skills, mental illness, and drug abuse. Federal, State, and local housing policies will need to be reformed and health care and job training services to the deinstitutionalized chronically mentally ill and unemployed must be augmented. Unfortunately, many of the sources of Federal help are scheduled for cutbacks, some for termination in the 1987 budget submission of the administration, and most are subject to sequestation under the Gramm-Rudman-Hollings provisions, even apart from the President's budget proposals.

On the bright side, in fiscal year 1986 FEMA received an appropriation for six staff positions to administer the Emergency Food and Shelter Program and the conference report for the fiscal year 1987 appropriations for FEMA continues to provide funds for these six full time staff positions. With the augmentation of FEMA's administrative capabilities, the agency will be better able to administer the program from within the agency (as opposed to its reliance upon nongovernmental organization in the early program phases). It is likely that the increase in the size of the permanent staff will provide FEMA with stronger, continuing role in the administration of the program. Also, the results of the transitional demonstration program will be monitored by the Congress to assess the need to continue such assistance. Finally the TEFAP authorization will expire at the end of the fiscal year 1987. Congress will likely consider reauthorization legislation in 1987 which may focus on the level of the Federal contribution for transportation and storage costs and whether to continue requirements for State matching.

C. EDUCATION

1. BACKGROUND

State and local governments have long had primary responsibility for the development, implementation, and administration of primary secondary, higher education, and continuing education programs benefiting students of all ages. The role of the Federal Government in education has been to ensure equal educational opportunity, to enhance the quality of education, and to address national priorities in training.

Federal and State interest in developing education opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a heirarchy of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The 1981 White House Conference on Aging report entitles, "Implications for Educational Systems," noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons, and assure a match between the needs of older adults and the training of those who prepare to serve them.

While many strong arguments exist for the importance of formal and informal education opportunities for older persons, in reality, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily to the establishment and maintenance of programs for children and youth, including those of the traditional college ages. This is due largely to the perception of education as a foundation constructed in the early stages of human development—a kind of intellectual investment drawn upon for discrete withdrawals throughout one's adult life.

While formal education is viewed as finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that a need exists for learning beyond the informal environment for the elderly. This need for structured learning may appeal among "returning students" who have not completed their formal education, older workers who require retraining in skills adaptable to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education for the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs have generally lagged, recently private and public-based education programs have emerged which are designed to better meet the growing educational needs of older persons.

2. ISSUES

(A) ADULT LITERACY

Literacy means more than just the ability to read and write. Literacy is more clearly defined as the essential knowledge and skills necessary for effective functioning in the home, community, and workplace. According to 1983 estimates, as many as 29 million Americans, or 1 in 5 adults, function with great difficulty in our society. An additional 49 million can function, but not proficiently. These figures mean an astonishing 78 million Americans function in society at a marginal level or below. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol and drug abuse—the cost of widespread illiteracy in this country is staggering.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the groups of adults 16 years and over with less than a high school education. Of those with less than a high school education, more than three-quarters aged 65 and over have not completed grade school. In the early 1970's, under a Federal education grant, the adult performance level [APL] study was undertaken at the University of Texas. The objective of the study was to develop a more complex set of reading and writing competencies that were related to adult economic and educational success in contemporary American society (Northcutt, 1975). The study developed a set of five general knowledge areas and four sets of primary skills. The knowledge areas were: Consumer economics, occupational knowledge, community resources, health, government, and the law. The primary skills were: Communication (reading, writing, speaking, and listening), computation, problem solving, and interpersonal relations.

The APL project established three levels of functional competencies: APL 1, APL 2, and APL 3. Adults in the APL 1 category are functionally incompetent (or function with difficulty) and have skills that are associated with (but do not determine) inadequate income at the poverty level or lower, inadequate education equivalent to 8 years of school or less, and are unemployed or have occupations of low job status. Adults in the APL 2 category are marginally functional (or competent, or "just get by") and have skills associated with income above the poverty level (but no discretionary income), education of 9 to 11 years of school, and occupations with median job status. Adults in the APL 3 category are functionally proficient and have mastered the skills associated with high levels of income, completion of at least 12 years of school, and high job status.

The APL study (represented in table 12-2) and Census Bureau illiteracy tabulations in table 12-3 reveal the acute problem older Americans face as the most illiterate segment of our society.

TABLE 12-2.—ADULT PERFORMANCE LEVEL [APL] PERCENTAGES, 1975

[In percent]

Category	APL competency level		
	Incompetent	Marginal	Proficient
Overall competency	20	34	46
Ages:			
18 to 29	6	35	49
30 to 39	11	29	60
40 to 49	19	32	49
50 to 59	28	37	35
60 to 65	35	41	24

Source: Northcutt, 1975.

TABLE 12-3.—PERCENTAGE OF THE AMERICAN POPULATION ILLITERATE, 1979

Age	Total	White	Black
All persons 14 years and over	0.6	0.4	1.6
Persons 14 years to 24 years	.2	.2	.2
Persons 25 years to 44 years	.3	.3	.5
Persons 45 years to 64 years	.8	.6	2.6
Persons 65 years and over	1.7	1.1	6.8

Source: U.S. Bureau of the Census, 1982, Table 8 (footnotes omitted).

Generally, the higher educational system in the United States has failed to address the needs of the older, illiterate adult. Although adult education programs exist throughout the country, only 2.6 million participate in the programs today, and most have a higher education level than the median for older adults. It has been suggested that Federal education programs designed to meet specific, categorical objectives have been responsible, in part, for the failure to prevent adult illiteracy. Advocates of the block grant approach toward social services funding, including the Reagan Administration, have suggested that this approach would reduce administrative costs and increase overall coverage and flexibility in literacy initiatives. However, specific targeting requirements and regulations would need to be an integral part of any program consolidation because recent evidence indicates that adult education funds would be otherwise used to serve persons who require less extenstive literacy training. In other words, the reduced payments which often accompany block grant funding could prove to be an incentive for States to allocate their scarce dollars to those persons who require less resources to train—those with better jobs, more education, and higher incomes. The ambiguity surrounding the block grant approach makes any comprehensive reordering of literacy priorities problematic.

In response to the President's Commission on Excellence in Education report concerning the quality of education in America, the Reagan Administration made the elimination of iliteracy a major focus. The Adult Literacy Initiative was launched in the Department of Education on September 7, 1983. According to the statement by former Secretary of Education Bell, the initiative is designed "to increase national attention to the promotion of adult literacy and to enhance existing literacy programs, whole utilization of the Department's experitise in coordinating literacy programs nationwide" (Bell, 1983). The initiative is not a legislatively mandated program, but is based on various discretionary authorities available to the Secretary of Education.

The initiative's current operations include: (1) Cooperating with the Coalition for Literacy and the Adverising Council in sponsoring a national awareness campaign on adult literacy, including an "800" number literacy hotline; (2) redirecting part of the college work-study program to employ students in literacy programs; (3) encouraging student and adult volunteers as literacy tutors; (4) working with the Federal Employee Literacy Training [FELT] Program, whereby all Federal agencies are encouraging employees to volunteer as literacy tutors; (5) sponsoring national meetings and conferences; and (6) developing private/public sector partnerships, including support for the Business Council for Effective Literacy (Bell, 1983; U.S. Department of Education, 1985a and 1985b).

(B) ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (Public Law 89-750) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to establish adult education programs that will enable adults 16 years and older to: (1) Acquire basic skills needed to function in society, and (2) assist them in continuing their education until completion of secondary level, if desired. Funds provided for adult education support State formula matching grants to combat functional illiteracy for adults over 16, and are distributed by a formula based on the number of adults in a State without high school diplomas who are not currently enrolled in school.

In 1977, a major change began in adult education enrollment. The enrollment of those aged 16 to 44 decreased while the enrollment of these age 45 to 65 increased. A 1981 survey entitled "Participation in Adult Education" conducted by the National Center for Education Statistics revealed that 768,000 persons age 65 and older, or 3.1 percent of all older Americans, participated in educational activities. Although the majority of adult education participations are under 35, this marked the highest number and proportion of older people involved in adult education ever recorded by NCES. Even more dramatic—the number of persons 65 and older participating in adult education has almost tripled, growing at the average rate of 30 percent for every 3 years compared to an average rate of 12 percent for adult participation of all ages.

Nevertheless, with only 3.1 percent of the elderly population enrolled in an educational institute in 1981, older people continue to be underrepresented in education programs in relation to their proportion of the total U.S. adult population. This is due partly to the fact that while older persons certainly have the ability to learn, the desire to learn is a function of educational experience. For example, the NCES reported in 1981 that the level of participation in adult education rose at each higher educational level from 2.2 percent of the total population with less than an 8th grade education to 31 percent with 5 years of college or more. Further, a 1981

NCCOA/Harris survey supports this correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment amd life-coping skills and are gradually shifting to educational programs on self-sufficiency. Few programs currently exist to meet the growing demand for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift their emphasis from "personal interest" courses to include job-training skills.

The Reagan Administration has proposed consolidating Federal aid to vocational education and adult education programs into a simplified block grant to States. Concern was raised, however, that this proposal ignores fundamental differences between vocational education—which serves those adults who require retraining for employment, and adults education—which acts as a basis for learning in later life, and would only weaken these successful programs. As a result, Congress consistently rejected this proposal to simplify the program and increase States' discretion, and it was not recommended by the administration this year.

(C) HIGHER EDUCATION

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and were able to identify them as peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

In response to this challenge, some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. At Smith College, for example, the Ada Comstock Scholar Program offers a traditional education to women older than undergraduates of traditional age. Older students are fully integrated into the academic and campus life, although Ada Comstock students are allowed to take as long as they need or want to complete their college requirements. The older students, in return, bring an added dimension and vitality to the classroom by sharing their broad-based life experiences and interest in learning.

For those older students who cannot afford the cost of a private college, some States are moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit in State-supported institutions.

Since only two States provide reimbursement to individual institutions which waive tuition payments, the participating colleges must make substantial investments in terms of curricular emphasis and financial support toward meeting the needs of older students.

(D) ELDERHOSTEL

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the conviction that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most elderhostel programs deliberately avoid age-specific focus on the problems of aging.

Since the inception of elderhostel in New Hampshire in 1975, dramatically increasing numbers of older adults have enrolled in this program. In 1984, over 700 private and public colleges and educational institutions in 50 States and Canada served 80,000 summer and academic year hostelers. In addition, over 5,000 hostelers participated in programs in Scandinavia, France, Germany, the Netherlands, Italy, and Great Britain. Even with the burgeoning numbers of participants, however, elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

(E) INTERGENERATIONAL PROGRAMS

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. There are now more than 100 intergenerational school programs nationwide. Over 250,000 volunteers participate in grades kindergarten through 12th.

Intergenerational school programs range from informal and haphazard to large, centrally organized programs reaching over several school districts. One such "model" program is the Senior Citizen School Volunteer Program [SCSVP] established at the University of Pittsburgh as part of the Generations Together consortium of intergenerational programs. SCSVP is a nonprofit independent program that contracts with individual school systems which have demonstrated an interest in developing or maintaining a school volunteer program. In 1983–84, SCSVP placed some 345 volunteers over age 55 in over 60 schools in western Pennsylvania.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children, and to better cope with their own personal trauma, such as the death of a spouse or friend. These programs also allow schoolchildren to develop a more positive view of older persons and aging while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components: (1) Establishing an information bank of intergenerational programs across the country; (2) disseminating this information to organizations interested in establishing such programs; (3) working with professional organizations to stimulate interest; and (4) funding intergenerational demonstration projects.

2. LEGISLATION

On October 19, 1986, President Reagan signed into law a measure reauthorizing the Higher Education Act through 1991, the Higher Education Amendments of 1986 (Public Law 99-498). The act authorizes up to $10.2 billion for Federal higher education programs in fiscal 1987, down $1.7 billion from the $11.9 billion authorized for fiscal year 1986. This legislation has some impact on higher education programs affecting older Americans. For example, the act authorizes the Education Department to make grants to institutions for research on the problems of adult learners, although it does not provide a specific funding level for this activity. Another section of the bill provides that under a State grant program authorized in 1984 by the Carl D. Perkins Vocational Education Act (Public Law 98-524), States must spend their allotments, 43 percent for vocational education program improvement, innovation, and expansion, and the other 57 percent for vocational education programs for special populations and activities, such as adults in need of training or retraining.

There were no other significant legislative activities directly related to the education of older persons in 1986.

3. PROGNOSIS

Rapid technological change in our society is intensifying the need for lifelong learning, and is placing a greater emphasis on acquiring new job skills. A major consideration in the issue of educating and retraining older workers is the projected labor shortage in the coming decades. For those older workers who view early retirement as an opportunity to change career direction, this trend represents an opportunity to remain an active and productive member of the work force. The linkage between older workers and the labor market, however, will require a commitment of resources for education, career counseling, and training, which is unlikely to be available in the near future.

While legislation passed in 1984 and 1985 reflected Congress' intent to support programs such as library services and adult education, the overwhelming majority of Federal dollars continues to fund programs for educationally disadvantaged children and youth. As part of their efforts to reduce Federal overhead, the Reagan Administration has urged a reduced Federal role in education programs across the board. Thus, the intergenerational struggle that has emerged over scarce Federal resources between the burgeoning elderly population and historical benefactors—youth and children, will rest on such fundamental public policy issues as educational equity and access. The resolution of these critical issues will depend on the ability of each group to register their interests and demands with public policymakers at both the State and Federal level. On the other hand, it is very possible that by way of the Gramm-Rudman-Hollings approach to cutting the deficit, Congress may turn an equally deaf ear to all age groups.

In order to adequately address the educational needs of older persons, greater attention needs to be devoted to providing the supportive services, such as transportation and career counseling, which help older students enjoy successful learning experiences. Federal, State, local and private sector initiatives need to focus on the types of educational programs suitable for older persons, and action needs to be taken to increase participation for those older adults with less education, especially the illiterate. With the graying of America, now seems the appropriate time to refocus our educational programs, and commit our resources to enhancing the educational opportunities of older persons, as well as the young.

D. OLDER AMERICAN VOLUNTEER PROGRAMS [OAVP]

1. Background

The Older American Volunteer Program [OAVP], which includes the Retired Senior Volunteer Program [RSVP], the Foster Grandparent Program [FGP], and the Senior Companion Program [SCP], is the largest of the ACTION program components. For fiscal year 1987, OAVP funding constituted 68 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 years of age and over to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies which recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local resources. According to ACTION estimates, State funding to support ACTION-funded volunteer projects is estimated at over $19 million annually—$10 million for the FGP, and $4 million for the SCP, and $5 million for the RSVP. In the past few years, State funds generated to support each of the programs have exceeded the Federal requirements for matching funds. To a great extent, the fact that these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services, have made them enormously popular with both Congress and the administration.

(A) RETIRED SENIOR VOLUNTEER PROGRAM [RSVP]

RSVP was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on

Aging to ACTION, and in 1973, the program was incorporated under title II of the Domestic Volunteer Service Act. The program is designed to provide volunteer opportunities for persons 60 years and over in a variety of community settings. In fiscal year 1986 there were approximately 374,000 RSVP volunteers; these older Americans are estimated to have generated more than 67 million volunteer hours. In fiscal year 1987, it is estimated that 383,000 older persons will be participating in this program.

Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, crime prevention, refugee assistance, and housing rehabilitation. RSVP sponsors include State and local governments, universities and colleges, community organization, and senior service groups. Each project is locally planned, operated, and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses incurred as a result of the volunteer activities.

(B) FOSTER GRANDPARENT PROGRAM [FGP]

The FGP Program was originally developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, FGP was incorporated under title II of the Domestic Volunteer Service Act.

The FGP is designed to provide part time volunteer opportunities for low-income persons 60 years and over to assist them in providing supportive services to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis for three or four children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receive an hourly stipend, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. The Domestic Volunteer Service Act prohibits stipends from being subject to tax and from being treated as wages or compensation. Foster grandparent volunteers must have an income which is below the higher of 125 percent of the DHHS proverty guidelines, or 100 percent of those guidelines plus the amount each State supplements the Federal SSI payment. This annual income level was $6,875 for an individual in most States and $9,250 for a two-person family in 1986. For fiscal year 1986, ACTION estimates that about 17,300 foster grandparents assisted approximately 62,000 children on a given day. In fiscal year 1987, it is estimated that about 17,700 older adults will participate.

(C) SENIOR COMPANION PROGRAM [SCP]

The SCP was authorized in 1973 by Public Law 93-113 and incorporated under title II, section 211(b) of the Domestic Volunteer

Service Act of 1973. The Omnibus Budget Reconcilation Act of 1981 amended section 211 of the act to create a separate part C containing the authorization for the Senior Companion Program. This program is designed to provide part-time volunteer opportunties for low income persons 60 years of age and over to assist them in providing supportive services to vulnerable, frail older persons. The volunteers assist homebound, chronically disabled older persons to maintain independent living arrangements in their own places of residence. Volunteers also provide services to institutionalized older persons. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. In order to participate in the program, volunteers must meet the same income test as described above for the Foster Grandparent Program.

In fiscal year 1986, about 5,400 SCP volunteers served in 112 projects, including 900 volunteers in 16 nonfederally funded projects. ACTION estimates that these volunteers served about 20,650 persons.

2. Issues

In recent years, there has been strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in the society. Historically, volunteerism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social services agencies. In more recent years, volunteer service has included activities for grassroots political advocacy and community improvement programs.

The Federal role in encouraging voluntary efforts has been coordinated through the ACTION agency. ACTION was established in 1971 under a reorganization plan which consolidated seven existing volunteer programs into a single independent agency. ACTION was granted statutory authority in 1973 under the Domestic Volunteer Service Act, which repealed previous legislative authorities for the component programs and authorized several new volunteer activities. Programs authorized under the DVSA and administrative by ACTION include Volunteers In Service To America [VISTA], service learning programs, special volunteer programs, and the older American volunteer programs [OAVP]. Since its inception as a Federal program, ACTION agency volunteers have been involved in programs designed to reduce poverty, help the physically and mentally disabled, or serve in a variety of other community activities.

The need continues in many communities for volunteer efforts which address the problems of poverty and utilize the skills and experiences of the elderly. A central theme of the Reagan Administration and a major focus of the President's Task Force on Private Sector Initiatives has been to encourage increased individual and corporate responsibility in meeting local economic and social service needs. As part of the President's new federalism initiatives, increased emphasis has been placed on shifting funding and management responsibility for many community services from the Federal level to the State and local governments, and to the private sector. For example, the administration has proposed eliminating the community services block grant—the community action program designed to provide services which have a measureable impact on the causes of poverty—and replacing it with initiatives to encourage the development of private sector antipoverty activities. Notably, reduced funding for the CSBG has resulted in greater reliance on volunteers rather than trained professionals to administer and implement services in the community. As this shift in Federal policy continues, greater pressure in helping to meet human needs will be directed toward the voluntary sector.

3. LEGISLATION

On December 12, 1985, the President signed into law fiscal year 1986 appropriations legislation for the OAVP (Public Law 99-178) as part of the appropriations for the Department of Labor, Health and Human Services, and related agencies. The fiscal year 1986 appropriations for the OAVP were as follows: RSVP $29.62 million; FGP, $56.1 million; and SCP, $18.09 million. These levels were identical to those enacted for fiscal year 1985.

Authorizations of appropriations for the Domestic Volunteer Service Act were to expire at the end of fiscal year 1986; therefore the act was reviewed during the 99th Congress. On October 27, 1986, Public Law 99-551 (H.R. 4116) was signed into law, extending the volunteer programs through 1989 at the following levels:

[In millions of dollars]

	1987	1988	1989
VISTA	25.0	26.0	27.0
RSVP	32.0	33.3	34.6
FGP	60.0	62.4	64.9
SCP	29.7	30.9	32.2

This legislation also amended the FGP and SCP programs to permit enrollment of non-low-income persons to serve as foster grandparents and senior companions as long as they are willing to serve without a stipend or reimbursement for expenses other than for transportation, meals, and out-of-pocket expenses, and agree to work 20 hours a week as well as comply with other program requirements. Prior law allowed only enrollment of older persons who met specific income eligibility requirements. Non-low-income, nonstipended individuals may participate in the program only in communities where there are no RSVP volunteers (such volunteers do not receive stipends). The new law specifies that nonstipended volunteers cannot replace low-income persons who serve as volunteers without stipend, and that Federal funds may not be used to support any costs incurred for nonstipended volunteers. Instead, the cost of administering programs for nonstipended volunteers may be supported by funds received by the Director of ACTION as gifts, funds contributed by volunteers, or locally generated contributions in excess of the required matching share for the volunteer programs.

E. TRANSPORTATION

Transportation is the vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs; maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need. Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support the individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

1. BACKGROUND

Three strategies have marked the Federal Government's role in providing transportation services to the elderly: Direct provision—funding capital and operating costs for transit systems, reimbursement for transportation costs, and fare reduction. As part of the Reagan Administration doctrine, it has been proposed in fiscal years 1981–85 to eliminate or substantially reduce Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems.

The major federally sponsored transportation programs that provided assistance to the elderly and handicapped are administered by the Department of Health and Human Services [HHS] and the Department of Transportation [DOT]. Under HHS, a number of programs provide specialized transportation services for the elderly. These include title III of the Older Americans Act, the social services block grant, the community services block grant, and to a limited extent Medicaid, which will reimburse elderly poor for transportation costs to medical facilities. Under the CSBG, more dollars are spent on so-called linkages with other programs—including transportation for the elderly and handicapped which links clients to senior centers, community and medical services, than on any other program category.

The passage of the Older Americans Act [OAA] of 1965 has had a major impact on the development of transportation for older persons. Under title III of the OAA, States are required to spend an adequate porportion of their title III–B funds on three categories: Access services (transportation and other supportive services); inhome services; and legal services. In fiscal year 1986, 8 million persons were recipients of transportation services under the OAA. This level of participation and funding indicates the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act of 1964, section 16(a) and 16(b) (Public Law 98-453), marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities for improved access by the elderly and handicapped. Section 16 of UMTA declares it to be the national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to the elderly and handicapped persons of mass transportation is assured; and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. Essentially, the goal of section 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavailable, insufficient or inappropriate.

Another significant initiative in the last decade was the enactment of the National Mass Transportation Assistance Act of 1974 (Public Law 93-503) which amended UMTA to provide mass transit funding for urban and nonurban areas nationwide through block grants. Under the program, block grant money can be used for capital operating purchases at the localities discretion. The act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours. Also, passage of the Surface Transportation Assistance Act of 1978 provided funding at the Federal level to support public transportation program costs, both operating and capital for nonurbanized areas. Programmatic changes to these provisions were made through the Surface Transportation Act of 1982 (Public Law 97-424) which reauthorized UMTA.

The programs administered by HHS have proved highly successful in providing limited supportive transportation services necessary for linking needy elderly and handicapped persons to social services in urban and suburban areas. The DOT programs have been the major force behind mass transit construction nationwide and continue to provide basic funding sources for primary transportation services for older Americans. Despite these program initiatives, the Federal strategy in transportation remains essentially one of providing "seed money" for local communities to design, implement, and administer transportation systems unique to their individual needs and resources. In the future, the Federal response to the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and to a large extent, the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

2. Issues

(A) TRANSPORTATION SERVICES FOR THE RURAL ELDERLY

Transportation was cited as one of the major barriers facing the rural elderly in a report published by the Senate Special Committee on Aging in September 1984. According to the report, an estimated 7 to 9 million rural elderly lack adequate transportation and as a result, are severely limited in their ability to reach needed services. The isolation of rural areas, along with the more limited availability of resources and uncertainty of institutional support, makes the transportation problems of rural elderly more acute than for their urban counterparts. Roads are sometimes narrow and poorly paved, further hampering travel for the rural elderly. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility, not program design.

Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas, complicate the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares which are necessary to support a rural transit system. Further, the physical design and service features of public transportation, such as high steps, narrow seating, and unreliable scheduling discourage participation by the elderly.

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. In an effort to draw attention to these critical transportation issues, specific recommendations were made during the 1981 White House Conference on Aging directed at improving rural transportation for the elderly. A miniconference on transportation for the aging, which preceded the general conference, recommended that State transportation agencies play a central role in developing responsive rural systems, with implementation for such a system initiated at the local level in order to ensure appropriate design for the unique needs of the individual community. The conference also recommended greater citizen participation at the policymaking level as well as at the advisory and implementation levels of transportation programs.

(B) TRANSPORTATION SERVICES FOR THE SUBURBAN ELDERLY

The graying of the suburbs is a phenomenon which has only recently received attention from policymakers in the aging field. Since their development following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have elapsed since that time have changed entirely the profile of the average American suburb; the suburbs have aged with profound implications for social services design and delivery. In 1980, for the first time a greater number of persons over age 65 lived in the suburbs, 10.1 million, than in central cities, 8.1 million.

The availability of transportation services for the elderly suburban dweller is limited. Unlike large metropolitan cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services generally.

Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent, and consists mostly as a supportive service. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Often, alternative revenue sources are not politically expedient. For example, user fees alone are insufficient to support suburbanwide services and are generally viewed as penalizing those persons who are in most need of transportation services in the community—the elderly poor.

In 1984, researchers at the State University of New York in Albany received a grant from the National Institute of Child Health and Human Development to study the implications of older suburban populations on public policy, including transportation services. Their studies show that suburbs with a larger number of elderly have adjusted to the needs of their dependent population by providing substantially higher levels of municipal services than the typical suburb. However, this has been accomplished through a heavy reliance on high property taxes. The fact that communities with the greatest demand from services for the elderly are precisely the communities which lack a tax base to support these expenditures has intensified the fiscal squeeze; many have already reached the constitutional limit on taxing authority. Thus, other sources of revenue are being tapped, such as lotteries and user fees, to help fund these additional community services.

That fact that the suburbs have aged has several implication for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a unique challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a particularly critical need. Institutions which serve the needs of elderly persons, such as hospitals, senior centers, and covenience stores must necessarily be designed with supportive transportation services in mind. Further, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community in order to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems such as dial-a-ride and van pools. Alternative funding mechanisms such as reduced fares, user fees, and other local taxes need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the degree that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand reexamination.

3. Legislation

Funding for the most crucial transportation programs serving older Americans was put on hold during the closing days of the 99th Congress when H.R. 3129, the Surface Transportation and Uniform Relocation Assistance Act of 1986, died in conference committee. Money for section 16-b2, which provides funds to private nonprofit groups to meet special transportation needs of the elderly and handicapped, and funds for a new program designed to serve as an information base, collecting data on rural and other specialized programs—including transportation for the elderly, were held up indefinately when lawmakers were unable to come to agreement on several unrelated issues prior to the October 18 adjournment.

Funding for the new program ($5 million) along with a $35 million appropriation for section 16-b2 cannot be spent until a transportation reauthorization bill is passed. While this is a setback for transportation programs, Congress approved appropriations increases for section 16-b2 and section 18 of 20 percent and 25 percent respectively. Section 18 funds rural areas to provide public transportation and is not affected by the lack of an authorization bill because it receives money from a general fund.

The House passed a transportation reauthorization bill on August 15 that would have covered section 16-b2 and section 18 for 5 years, and the Senate passed its version of the bill, authorizing the programs for 4 years, on September 24. Currently, section 16-b2 in authorized at $38.5 million with section 18 at $89.4 million. Both the House and Senate bills would have increased future authorizations for section 16-b2, and reduced section 18 authorizations to bring it closer in line with current appropriations levels.

Despite this setback and the fact that money for section 16-b2 could run out completely—forcing transfers from other programs, Congress appears intent on an early reauthorization in the 100th Congress. The House passed H.R. 2 to address this situation on January 21, 1987, and the Senate passed its substitute bill, S. 387, on February 4, 1987. At the time of this printing, a conference committee has been formed.

4. Prognosis

The demographic and social changes anticipated in the coming decades will have profound implications for planning and implementing social services for the elderly, particularly transportation programs. According to a report published by the Department of Transportation in April 1983, on transportation and elderly, the implications of social and demographic changes on future transportation policy include:

—The demands of the elderly for specialized transportation will increase in the 1980's. This is apparent from the sheer rise in the number of older people, and in the expected increased costs of fuel, the increase in costs of purchasing and owning an automobile, and an established and growing demand for mobility among the elderly.

—Most of the riders of specialized transportation services are likely to be female, of advanced age, and members of minority groups. The economic position of about one-sixth of the aging population, approximately 5 million persons, will constitute the core group who are likely to be transportation disadvantaged, in the full sense of that term and candidates for specialized transportation services.

—Specialized transportation programs will need to consider serving on older, less physically able population than heretofore. The marked growth of the 85 years and older population will place increasing demands on the specialized transportation network. That network will need to take into account a group of riders who will have some difficulty in walking yet want to maintain a measure of mobility and independence.

In view of increasingly limited Federal participation in transportation services, the role that State and local governments play in this area will become of major significance to needy elderly and handicapped persons. States will need to reassess priorities with attention toward replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in terms of the provision of transportation services to older Americans. A report undertaken for the Administration on Aging on the transportation problems of older Americans indicated that many agencies servicing the elderly already use volunteers extensively in their programs. Given the stringency in resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

The trend toward block grant programs implies a broader range of roles and reinforces the need for advance system planning and priority service setting at the State and local level. Since block grant programs are linked with lower absolute funding levels, and since programs funded by discretionary appropriations from general revenues are becoming particularly vulnerable, the relationship between individual State and local governments will need to be better defined if cooperative fiscal efforts by these jurisdictions are to function successfully. Until these relationships are clarified and secured, access by older Americans to the array of community services may continue to be severely hampered.

F. LEGAL SERVICES

1. OVERVIEW

Older persons, because of difficulties of access and unique legal problems, have a special need for legal services. This is primarily a result of the low income status of many older persons and the complex nature of the programs upon which the elderly are so dependent. After retirement, most older Americans are dependent upon government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security Program for income security and on the Medicare and Medicaid Programs to meet their health care needs. These benefit programs are extremely complicated and often difficult to understand for persons inexperienced with government.

In addition to governmental benefits, legal problems of older persons typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home, and probate matters. Legal services and professional legal representation by those who know the law are of vital importance to the elderly because it helps them to obtain basic necessities and assures that they receive benefits and services to which they are entitled and for which they have worked all their lives.

Unfortunately, older persons encounter special problems in gaining access to legal services. A large number of older persons, particularly those who qualify for many benefit programs, cannot afford to hire a private attorney. Others are not comfortable accepting free or low cost legal services and others are simply wary of dealing with members of the legal profession. In addition, many older persons may fail to recognize some of their problems as legal problems and may not be aware of existing legal services. Finally, many older Americans face specific barriers to legal services because of lack of transportation, physical handicaps, fear of crime, and difficulty in communication.

The national population segment from which the need for elderly legal services arises is large and growing. Private bar efforts alone fall far short in providing for the needs of older Americans for legal help. In addition to legal services provided by the private bar, a number of existing Federal programs provide legal services for older persons. Services funded through the social services block grant established under the Omnibus Reconciliation Act of 1981, the Older Americans Act (OAA), and the Legal Services Corporation are among these programs. Of these three, the Legal Services Corporation [LSC] is the largest provider of legal services to low income elderly.

While everyone agrees that provision of legal services to the elderly is vital, there has been a controversy as to which legal services should be provided and how best to provide them. This dispute was touched off when, in 1981, President Reagan proposed to terminate the federally funded Legal Services Corporation. The broad controversy surrounding the provision of legal assistance to the poor can be seen in the history of the Legal Services Corporation and has been played out in the funding, authorization, and nomination process for the Corporation. While the controversy still goes on, it is significant that Congress has consistently opposed President Reagan's proposals to abolish the LSC.

2. BACKGROUND

(A) THE LEGAL SERVICES CORPORATION

Legislation creating the Legal Services Corporation (LSC) was enacted in July 1974. Previously, legal services has been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. President Nixon, however, recognized that because some of the litigation initiated by legal services brought it in direct conflict with local and State governments and because the program is concerned with social issues, it is subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, he requested legislation creating a separate, independently housed corporation. The Legal Services Program was then established as a private, nonprofit corporation headed by an 11-member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been admitted to a State bar. The Corporation also funds a number of national support centers, which develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field.

Legal services provided through Corporation funds are available only in civil matters and to any individual with an income no higher than 125 percent of the Office of Management and Budget poverty guidelines. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. According to the Corporation's 1985 annual report, almost one-third of legal services cases are family related, such as divorce and separation, child custody and support, and adoption. Another 19 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in non-Government subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems, form the next two largest categories of legal services cases. Individual rights, employment, health, juvenile, and education cases make up the remaining caseload. Most cases are resolved outside the courtroom.

At the national level, the LSC has funded national support centers which provide assistance to field attorneys and State support centers. Four of these centers are specifically involved in issues that confront older people. They are the National Senior Citizens Law Center [NSCLC], in Los Angeles and Washington, D.C.; Legal Counsel for the Elderly [LCE], in Washington, D.C.; and Legal Services for the Elderly [LSE] in New York City.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several others have been added since then. Most of the restrictions were made in response to the critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys, in the guise of providing legal assistance to the poor. They believe that although legal services attorneys are theoretically prohibited from pursuing their own political and social interests by a requirement that they must be representing a particular client before getting involved in an issue, this requirement is easily circumvented without specific restrictions. The current restrictions include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The appropriations measure currently in effect contains further prohibitions against lobbying with Corporation funds, representing aliens who do not meet specified conditions, and class action suits against Federal, State, or local governments except under certain circumstances.

Other restrictions were promoted by supporters of legal services who were concerned that the broad scope of the Corporation's work would be sharply curtailed by its detractors. For example, the current appropriations measure also requires prior notification of Congress when regulations are to be promulgated. This restriction was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would drastically change existing policy within the Corporation.

(B) OLDER AMERICANS ACT

Support for legal services under the Older American Act (OAA) was a subject of interest to both the Congress and the Administration on Aging [AoA] for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were among those made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 identified, for the first time, legal services as eligible for funding under title III of the OAA. Amendments to the OAA, in 1978, established a funding mechanism and a programmatic structure for legal services. Area agencies on aging are required by the Older Americans Act to allocate an adequate proportion of title III supportive services funds for legal assistance. The 1984 amendments to the act added a requirement that area agencies annually document the amount of funds expended for this assistance. The act also requires that area agencies contract with legal assistance providers which can demonstrate the experience or capacity to deliver legal assistance and to involve the private bar in legal assistance activities. Where the legal assistance grantee is not a Legal Service Corporation grantee, that provider is required to coordinate services with LSC-funded programs in its area.

Unfortunately, the total amount of title III funds expended on legal services for recent fiscal years is not available. As part of its past efforts to reduce State reporting burdens, AoA discontinued the requirement that States report expenditure data on types of services. The Legal Services Corporation, however, reported that it received $10.2 million in OAA moneys in 1985. According to the AoA fiscal year 1985 program performance report, the total number of persons who received legal services was about 525,000.

The OAA requires State agencies on aging to establish and operate a long-term care ombudsman program which, among other things, investigates and resolves complaints made by or on behalf of older residents of long-term care facilities. The 1981 amendments to the OAA expanded the required scope of the ombudsman to include board and care facilities. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal and protective services activities for older people and to assure coordination of these activities. State ombudsman reports indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to facilities, residents, and resident's records; provide consultation to ombudsman on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs; and work with ombudsmen and others to bring about changes in policies, laws, and regulations which benefit older persons in institutions.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, provide services directly or contracts with public and nonprofit social service agencies for providing social services to persons and families. States, for the most part, determine which social services to provide and for whom they shall be provided, Services may include legal aid. Because the Reconciliation Act and the Department of Health and Human Services have eliminated much of the reporting requirements previously included in the title XX program, very little information is available on how States have responded to both funding reductions and changes in the legislation. Thus, there is no information available on the number of persons or the age breakdown of those persons who are being served.

3. Issues

(A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. Federal legal services reporting systems count older persons on the basis of those over the age of 60. Over 36 million Americans were over 60 in 1982, or roughly 16 percent of the population. Persons over 60 constitute 14.6 percent of all persons below the official Government poverty line. This is approximately 5 million persons. Under current eligibility requirements, individuals with incomes up to 125 percent of the poverty line may be eligible for LSC funded legal assistance. Using this standard, approximately 8.7 million persons over the age of 60 are LSC eligible persons. Unfortunately, there is no precise way of determining eligibility for legal services under the Older Americans Act since eligibilty is based both upon economic and social need, and means testing for eligibility is prohibited. An expert in the field has stated that if one were to consider the potential clientele for Older Americans Act legal services as those realistically unable to afford legal assistance, a majority of older persons would qualify for such assistance. Fully two-thirds of persons over 65 in 1980 had incomes of less than $8,000 per year. Of older persons over 65 and living alone, more than 60 percent had annual incomes of less than 5,000 a year, and 75 percent had annual incomes of less than 7,000. It is clear that a substantial percentage of older persons are poor or near poor and would find it difficult to purchase legal representation.

LSC programs handled and closed 1,346,000 cases in fiscal year 1985. Although programs funded under the Legal Services Corporation Act make services available to all low-income persons, persons 60 years of age and older constitute a sizable portion of the client eligible population. About 13 percent of the cases handled in 1985 involved a client age 60 and over. This figure represents a decrease over the 1982 level of 14 percent.

An essential component of legal services delivery systems for the elderly is the private bar. The expertise of the private bar is considered especially important in such areas as wills and estates, real estate and tax planning. Many elderly persons cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar is generally unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations, with little chance of generating a fee for services rendered. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, or low-fee or no-fee (pro bono) basis, the potential of the private bar to serve the elderly in need of legal assistance has not yet been fully realized.

The availability of legal representation for low-income older persons is also determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut back the flow of Federal dollars to local programs for the delivery of elderly legal services and there is no doubt that older persons are finding it more difficult to obtain legal assistance. When the Legal Services Corporation was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of 2 legal services attorneys for every 10,000 poor people. In contrast, in 1975, there were approximately 11.2 lawyers for every 10,000 persons above the Federal poverty line. In fiscal year 1980, the goal of minimum access was achieved with an appropriation of $300 million. Currently, however, the LSC is not funded to provide minimum access to legal assistance for poor persons. In most States, only 1 attorney serves 10,000 poor persons. To meet the minimum access level, the National Legal Aid and Defender Association estimated that the Corporation would have needed a fiscal year 1985 budget of $470 million.

In 1986, LSC reported progress on two fronts. The private attorney involvement (PAI) project requires each grantee to expend at least 12.5 percent of its basic field grant on the direct delivery of legal services by private attorneys (as opposed to LSC staff attorneys). LSC states that preliminary data indicate that the PAI requirement is an effective means of leveraging funds. They report that, in 1985, an analysis of PAI data for 1984 for 180 filed programs revealed that 48 programs (27 percent) had high PAI productivity based on an analysis of PAI expenditures and case closure data. Specifically, those programs closed a higher percentage of cases per $10,0000 of funding with PAI dollars than with dollars supporting staff attorneys.

LSC's law school clinical program allows the direct delivery of legal services to eligible clients and it affords third year law students the opportunity to learn the needs and problems of the less fortunate of their communities. LSC states that over 70 percent of law school student participants polled indicate that they feel more inclined to represent indigent persons in the future because of their experiences in the clinical program.

It should be noted, however, that these programs have been criticized by legal services staff attorneys. They claim that they have been unjustifiably cited to support less LSC funding and to divert cases from LSC field offices.

In 1981, Congress first reduced the funding to the LSC by 25 percent (from $321 million to $241 million). This funding reduction translated in the immediate loss of 1,793 attorneys and the closing of more than 108 local offices, making it more difficult for older persons with legal needs to gain access to legal representation. In fiscal year 1986, there were 323 legal services programs throughout the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices in 1986 was approximately 1,300, down from 1,475 in 1981. At the end of 1984, the LSC employed 4,767 attorneys, as compared to 6,559 in 1980.

Cuts in funding also coincided with a national economic recession creating a category of "new poor" and changes in Federal programs creating new legal needs for the poor. Since 1981, there has been an even further decrease in the LSC's ability to meet their clients' legal needs. Legal services field offices report having to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must now make hard choices about which poor person will be denied service and which will receive legal attention. A 1984 survey of LSC field offices stated that three-fourths of the responding programs believed that the level of unmet legal needs was greater than it had been in 1982 and only 13 percent of the programs believed that they met a greater amount of legal need in 1983 than in 1982.

(B) ALTERNATIVE PROVIDERS

Few people disagree that provision of legal services to the elderly is important and necessary. Yet there has been continuing controversy as to how best to provide these services. This dispute was touched off again when President Reagan proposed in 1981 to terminate the federally funded Legal Services Corporation and to include legal services activities in a social services block grant. Funds then going to the Corporation, however, were not proposed for inclusion in the block grant. The block grant approach is consistent with the administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and that allowing States to make funding decisions regarding legal services would make the programs accountable to elected officials.

At the time of this proposal, the administration revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges resparked a controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their problems are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the Government and businesses to enforce poor peoples rights have angered officials. Others protest against the use of group orientation methods on the basis that the poor can be protected only by allocation and litigation procedures which treat each poor person equally as a unique individual and not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits have been severely restricted.

President Reagan also justified his proposal to terminate the Legal Services Corporation by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a congressionally mandated study which found legal services provided by private attorneys to be as effective as those provided by staff attorneys hired directly by local legal services programs. Their approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation. Finally, the administration argued that regardless of the continued existence of LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals.

Supporters of federally funded legal services programs argue that neither State or local governments nor the private bar would be able to fill the gap in services created by abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will move forward to provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are not as likely to have this experience nor are they as likely to have the interest in dealing with the systematic abuses that poor people encounter.

Defenders of LSC say that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the Corporation and the private bar. One author has concluded that only about 15 percent of the legal problems of the poorest segment of the population receive any kind of legal attention. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their Government and to the whole system of justice. They contend that it is also inconsistent to assure low-income people representation in criminal matters, but not to provide them with legal assistance in civil cases.

4. Responses

(A) LEGISLATION AND CONGRESSIONAL ACTIVITY

(1) The Legal Services Corporation

(a) Budget Legislation

The LSC Act was reauthorized in 1977 for 3 additional years. At that time, much of the controversy surrounding the program, which grew from a perception that the program was one of social activism and reform rather than routine legal assistance, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has reemerged. This is due, in part, to the fact that every year since 1981, the Reagan Administration has announced plans not to seek reauthorization of the program and has requested no funding for it. Congress, however, has rejected these proposals and has responded with bipartisan support to restore funding.

Funding for the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in 1981. Since then, however, funding for LSC has been reduced. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. This level was maintained in 1983. $275 million was appropriated for the LSC in 1984 (Public Law 98-107). For fiscal year 1985, President Reagan again proposed to eliminate the Legal Services Corporation. The Corporation itself, however, requested $325 million. Congress passed and the President signed a measure (Public Law 98-411) providing fiscal year 1985 funds for a number of Federal agencies, including $305 million for the LSC.

Further provisions in Public Law 98-411 earmarked $2 million to the LSC to increase "quality legal services to the elderly" by: (1) Developing classroom and bar association source materials on law affecting the elderly for use by law schools, the private bar, legal services grantees, and in continuing education seminars; (2) developing plans to encourage attorneys to do more to provide better pro bono services for elderly and higher quality legal services; and (3) developing a clinical program to supplement local Legal Services Corporation grantees. The project also had to plan for the dissemination of results from the funded projects. In implementing this project, the Corporation solicited proposals nationwide. After extensive review, LSC granted $1.6 million to a total of 20 law school clinics, $140,000 for the development of six sets of source materials and $222,820 to a total of 11 private bar pro bono projects. The projects were funded in 1985 by the Elderlaw project and will continue operation over a 2-year period. LSC states that as the project moves into its second year of operation, it is progressing well. The first aspect of the Corporation's efforts to address the problems of the elderly involves the use of special educational programs on laws affecting the elderly and the development of source materials. Some of these materials are currently being distributed through Administration on Aging offices. LSC also reports that the pro bono projects have created information and referral networks, supplemented with a variety of educational manuals for the private bar. To date, LSC reports that the legal problems of more than 2,200 elderly clients have been handled by about 300 students.

A supplemental appropriation for fiscal year 1985, containing $8 million for the establishment of a new poverty law center in New Orleans and for a legal clinic at the Drake University School of Law in Des Moines, IA was signed into law on August 15, 1985 (Public Law 99-88). This brought total fiscal year 1985 funding to $313 million.

President Reagan requested no funding for the Legal Services Corporation for fiscal year 1986, but the Corporation requested $305 million. H.R. 2965, appropriating $305.5 million for the LSC for fiscal year 1986, was passed by Congress, and the measure was signed into law by the President on December 14, 1985 (Public Law 99-180). The bill states that all restrictions and limitations applicable to the LSC in fiscal year 1985 would continue to apply and it restored certain cuts anticipated by the Corporation for the national support center program, migrant programs, and supplemental field programs. Under the Gramm-Rudman-Hollings Act (Public Law 99-177), the LSC appropriation was reduced by 4.3 percent, or by about $13.1 million in March 1986.

For fiscal year 1987, the Congress appropriated $305.5 million for the LSC. Although the administration requested zero funding for LSC, the LSC submitted a budget directly to the Congress requesting this amount. The continuing resolution for fiscal year 1987, Public Law 99-500, earmarks the funding levels for each of the Corporation's line items in the bill to ensure that the Appropriations Committee's recommendations are carried out. This was deemed necessary because the Committee on Appropriations encountered great difficulty in tracing the funding activities of the Corporation and received very little detail from the Corporation about its proposed use of the funding request, despite repeated requests for information.

The bill also includes a legislative formula governing the allocation of funds for grants and contracts among the basic field programs. Language is also included to specify the procedure by which each grantee's funding level will be reduced in the event of another sequestration under section 252 of the Gramm-Rudman-Hollings law.

Finally, the bill has included language directing that provisions regarding legislative and administrative advocacy in Public Law 99-180 and the Legal Services Corporation Act of 1974, as amended, shall be the only valid law governing lobbying and shall be enforced without regulations. This language was included because the Corporation published proposed regulations which were believed to go far beyond the restrictions on lobbying which are contained in the LSC statute.

The continuing resolution provides that none of the funds appropriated for the LSC may be used to participate in any litigation with respect to abortion, except where the life of the mother would be endangered if the fetus were carried to term. Provisions effective in fiscal year 1987 that are continued from past years' appropriations include restrictions on lobbying, class action suits, representation of aliens, and language requiring prior notification of the Congress when regulations are to be promulgated.

(b) Monitoring and Compliance

During 1986, congressional concern about the LSC focused on the Corporation's procedures for monitoring and evaluating recipients and for conducting compliance investigations. Monitoring and compliance investigations are undertaken to determine whether a recipient has violated any applicable laws or grant agreements.

In 1985, in an effort to ensure that funds appropriated to the Corporation are used to provide quality legal services and in accordance with the LSC Act and regulations, the Corporation made significant changes in the performance and conduct of its monitoring of LSC recipients or grantees. The Corporation, for example, instituted central direction of the monitoring process. It also implemented more frequent monitoring visits, increasing their size and duration.

Critics of the new monitoring procedures state that the LSC is undertaking a witchhunt and that monitoring teams, unfavorably biased against the grantees, have harassed them. Controversy arose in the cases of some grantees when the Corporation refused to release draft reports of relatively recent inspections because the Corporation considered the reports to be unreliable. These same grantees were subsequently targeted for reinspection. As a result, some grantees have resisted LSC when it attempted subsequent audits. In turn, the LSC has complained of obstructions that prevent monitors from having sufficient access to the programs to conduct proper evaluations.

In 1986, the Corporation published for public comment and received extensive comment regarding new procedures for the denial of refunding (45 CFR 1625) and the investigation and resolution of the financial consequences of recipient violations (45 CFR 1630). The LSC Board adopted extensive changes in the procedures for denial of refunding and has stated that it is giving consideration to changes in proposed part 1630.

(c) Board Appointments

Since President Reagan took office in 1981, there has been continuing conflict between the White House and the Congress over appointees to the LSC's board of directors. During the summer of

1981, the appointments of all 11 LSC board members appointed by former President Carter had expired. President Reagan, however, did not appoint new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Between 1981 and 1984, he appointed a succession of people to the board on an interim basis. Because these appointments were made while Congress was in recess, they could serve without any Senate confirmation. During the same period, President Reagan announced a number of prospective nominees, but none were confirmed by the Senate. Some of them were opposed by liberals and moderates who questioned their qualifications and their commitment to legal services to the poor. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. In 1984, President Reagan granted recess appointments to 11 individuals he had unsuccessfully nominated earlier in the year. These people served without Senate confirmation, until the end of 1985. The names of these individuals, however, were also formally resubmitted to the Senate on January 3, 1985, when the Congress convened. Although a couple of the nominees were controversial and faced stiff opposition, all of them were approved by the Senate Labor and Human Resources Committee and subsequently by the full Senate on June 12, 1985.

In June 1986, the President resubmitted the name of three board members for a second 3-year term. The names of two client board members whose terms also expired in July 1986 were not resubmitted nor were their replacements named. All of the current board members will continue to serve the board until they are replaced by themselves or some other persons who have been confirmed by the Senate. In December 1986, the LSC announced the resignation of the President of the LSC, James H. Wentzel, who had served since July 1985.

(2) Older Americans Act

In the past, AoA made separate grant awards to all States from title IV funds for legal services and ombudsman activities. A 1984 amendment to the Older Americans Act changed the process of allocation of funds for legal and ombudsman services as well as for State agency on aging administration and State education and training activities, effective in fiscal year 1985. Prior to fiscal year 1985, State agencies on aging received separate awards of funds for various administrative activities from both title III (through a separate allotment of funds for administration), and from title IV grant funds for legal services and ombudsman activities and for State education and training activities. The 1984 amendment merged these various streams of funding and consolidated under title III State agency administration those portions of the State agency activities which has been funded out of title IV funds, namely, legal services and ombudsman activities and State education and training activities. During passage of the amendment, Congress gave assurances that States would not receive any less in fiscal year 1985 funding from all these sources than they had received in fiscal year 1984. Congress intended that separate awards of title IV funds for legal services and ombudsman activities (and for State education and training) continue to be made to those States which would not receive the "hold harmless" amounts. Fiscal year 1985 was the first year that this provision was in effect. In fiscal year 1986, AoA awarded from title IV funds about $2 million to 33 States and territories for legal services and ombudsman activities. The remaining States received a sufficient increase in their consolidated funding amounts (after application of increases in title III appropriations) for State administration, legal services, ombudsman activities (and for State education and training activities) that separate awards of title IV funds were not necessary.

Four national organizations have continued to receive funding from the Administration of Aging in 1986 to support legal services activities: Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons); the American Bar Association; the Center for Social Gerontology; and the National Senior Citizens Law Center. In addition, in 1986, the Administration on Aging awarded funds for 10 demonstration projects designed to demonstrate innovative ways to deliver legal services to the elderly. Demonstration grantees include statewide and countywide legal services providers and national organizations.

(B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such programs are gaining momentum, there is no precise way to determine the actual number of lawyers involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys. This assessment is noteworthy in light of the fact that President Reagan has justified his desire to abolish the LSC by saying that legal services for the poor could be provided more efficiently by members of the private bar.

A recent development in the delivery of legal services by the private bar has been the introduction in the United States of the IOLTA (Interest on Lawyers' Trust Accounts) Program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts in then channeled into federally funded, bar affiliated, and private and nonprofit providers of legal services. Thirty-nine States have already adopted some form of IOLTA and a reported $20 million has already been raised through this program across the country. The Legal Services Corporation reported receiving $2.6 million through IOLTA in 1985. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. Supporters of the concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how the money is spent. While there is no unanimity at this time among lawyers regarding IOLTA, it appears to have potential value as a needed funding alternative.

Another innovative idea is a legal hotline project which is being tested by Legal Counsel for the Elderly [LCE], a department of the American Association of Retired Persons. LCE was awarded a major grant from the Administration on Aging to create a free telephone legal advice and referral service for older people. The prototype, which became operational in June 1985, will serve the large metropolitan area of Pittsburgh, PA. There are plans to extend the hotline to a statewide service area and it could be replicated in other States. The major source of funding for the project will come from the law firms who receive the referrals and from the sale of wills.

In 1977, the then-president of the American Bar Association [ABA] was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1978. The commission was charged with examining four priority areas—provision of legal services to the elderly, discrimination against the elderly, simplification and coordination of administrative procedures and regulations, and issues involving long-term care. Subsequently, two new priority areas were added: Housing and Social Security. Since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The commission has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged. On such activity is the national bar activation project which provides technical assistance to State and local bar associations, law firms, corporate counsel, legal service projects, the aging network, and others in developing projects for older persons. It aims to generate pro bono, reduced-fee referral, and community educations programs for senior citizens, as well as relevant continuing legal education curriculums for attorneys. In addition, the project publishes a quarterly newsletter, Bifocal; acts as a clearinghouse for private bar activities to assist the elderly, and seeks to implement models which afford maximum cooperation among legal services projects, the private bar, and the Older Americans Act network of State and area agencies on aging.

The private bar has also responded to the needs of elderly persons in new ways on the State and local level. Currently, there are 40 State and local bar association committees on the elderly. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people to providing community legal education for seniors. Nearly 50 States and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In over 29 States, handbooks for seniors have been produced either by State and area agencies on aging, legal services offices, or bar committees, which detail seniors' legal rights. Since 1982, attorneys in over half the States have had an opportunity to attend continuing legal education seminars regarding issues affecting elderly people. The emergence of training options for attorneys which focus on financial planning for long-term care and advance directive are particularly noteworthy.

As recognized by the American Bar Association, private bar efforts alone fall far short in providing for the needs of older Americans for legal help. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is through the combined efforts of a continuing Legal Services Corporation, an effective Older Americans Act program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.

5. PROGNOSIS

Reductions in Federal funding have already caused serious cutbacks of existing legal service programs. Over the past few years, the LSC has been operating on a budget of a little over $300 million a year—only enough to provide about $9 a year in legal services for each poor person. Even this trifling outlay, however, has come under attack by conservatives and by those worried about Federal deficits. The Reagan Administration has been a harsh critic of the program and has tried to persuade Congress to dismantle the corporation. Legal services attorneys state that they already exclude large numbers of eligible individuals who have legitimate legal claims and that only those with the most severe emergencies are able to receive free legal services. Unfortunately, legal services was not within the scope of other proverty related programs that were exempt from Gramm-Rudman-Hollings cuts. Legal services suffered a 4.3 percent cut in the 1986 fiscal year. As Gramm-Rudman-Hollings deficit reduction targets move toward $0 in fiscal year 1991, across-the-board spending reductions in fiscal year 1987 could be even more devastating to the program. In addition, funding for the program could be cut as part of congressional budgets designed to meet the targets. While no significant infusion of funding can be expected in the near future, the one ray of hope is that Congress has thus far prevented Federal funding from being shut off.

It is a basic tenet in our society that those who live under the laws should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded Legal Services Program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. If we are to continue to make progress in the goal of equal justice and access for all, the continued funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

Chapter 13

FEDERAL BUDGET

Late in 1985, Congress took a significant step toward changing its handling of the Federal budget by enacting the Balanced Budget and Emergency Deficit Control Act of 1985, also known as "Gramm-Rudman-Hollings." Gramm-Rudman-Hollings established a new budget process in an effort to force agreement on the difficult deficit reducing decisions tying up the legislative process in recent years. The act is a radical departure from the previous budget process in that it sets deficit targets and provides for specific automatic reductions to achieve these targets in the event other deficit reducing legislation is not enacted first.

The constitutionality as well as the viability of Gramm-Rudman-Hollings was put in the test in 1986, the first full year for which the law was effective. As Congress and the administration struggled to agree on a budget which met the deficit target the law set for fiscal year 1987, the Supreme Court declared certain provisions of the law unconstitutional. By the close of the 99th Congress on October 18, 1986, the law had been modified to pass constitutional muster and the deficit targets had been met (at least under the prescribed agency projections). The law had "worked," but controlling Federal deficits will continue to challenge lawmakers in 1987 and beyond.

A. BACKGROUND

1. The Budget Process

The Constitution divides the Federal Government's powers between three branches. Congress, the legislative body in this scheme, must originate all law making. Congress may delegate to other bodies the power to formulate regulations, but these must conform to standards set by congressional legislation. One of the most important powers reserved to Congress is "the power of the purse"—the ability to tax and spend. Budgetary decisions ultimately rest with Congress, although the President has long had a substantial impact on taxing and spending decisions. In a 1921 budget act, Congress empowered the President to submit a budget proposal to the legislative, indicating his priorities and desires. This proposal has long formed the starting point for congressional debate on budgetary decisions, although it is not binding in any way.

The budget submitted by the President is comprehensive, however Congress makes its budgetary decisions in 13 separate general appropriations bills, each of which is the responsibility of one of the subcommittees of the House and Senate Appropriations Committees. Appropriations for a particular use must conform to specific "authorizing" legislation, enacted separately by Congress, before money can be appropriated to that use. Later in the process, Congress may provide further funding in the form of supplemental appropriations bills. When appropriations bills are not enacted before the start of the fiscal year, continuing appropriations bills are passed to allow governmental operations to continue.

2. ENTITLEMENTS

A significant amount of Federal Government spending now occurs in entitlement programs, such as Social Security, which do not require an annual appropriation. The rationale behind permanent appropriations entitlements is that Congress has created programs in which all who are entitled to benefits have a legally enforceable claim against the Government for those benefits, so Congress must pay out all amounts due unless and until changes in the laws establishing and governing those programs occur.

In recent years, many feel that entitlement spending has gotten out of hand. The large amounts of spending involved in permanent appropriations creates a system in which Congress is unable to address the budget as a whole. Authorizing committees generally are unwilling to reduce spending in programs under their control. Without some overall agreement to make cuts in entitlement programs, individual committees could not be expected to independently reign in entitlement spending.

3. CONTINUING RESOLUTIONS AND BUDGET RECONCILIATION

The lack of budgetwide vision, coupled with the lack of discipline among authorizing committees, led to the passage of the Congressional Budget and Impoundment Act of 1974. This act implemented a reformed budget process built around two annual concurrent budget resolutions.

The act set up a legislative timetable that focuses Congress' attention on the budget as a whole. The first step in the budget process is passage of a concurrent budget resolution, which sets out basic fiscal policies for taxing and spending to be pursued in the coming year. Congress then uses this tool to guide it in actions on specific appropriations bills, tax bills, and bills creating or changing entitlement programs. When these bills are completed, Congress enacts a second budget resolution, which allows Congress to reassess its individual legislative actions in relation to the budget as a whole. If the aggregate numbers in this second resolution are inconsistent with the total new budget authority provided or with the amount of revenues projected for the coming year, the act allows for a process known as "reconciliation." Reconciliation bills are designed to bring total spending and revenues in line with the second budget resolution before the start of each new fiscal year on October 1.

B. THE GRAMM-RUDMAN-HOLLINGS ACT

In recent years, Congress has become increasingly paralyzed within its budget process. Efforts to control the deficit in the context of appropriations bills have caused numerous delays in passage, and further differences complicated the ability to produce conference reports. Congress has resorted to a series of "continuing resolutions" to permit agencies and departments to continue to pay salaries and operate programs until their regular appropriations become law. Reconciliation bills have been delayed further and further each year, to the point where the reconcilation bill for fiscal year 1986 was not passed until April 6, 1986, more than 6 months after the start of the fiscal year on October 1, 1985.

The Federal deficit has increased at what many consider to be an alarming rate. The total national debt surpassed the $2 trillion mark in 1985. Concerned about the potentially harmful economic effects of spiraling debt, and spurred by constituent pressure to control the deficit, Congress searched for measures to enforce discipline in the budget process and limit congressional discretion. Measures proposed have included a constitutional amendment that would require Congress to report a balanced budget each year and legislation to provide the President with authority to veto individual line items in appropriations bills.

1. History of the Act

The need to raise the debt ceiling above $2 trillion in the fall of 1985 triggered a response in the Senate. In late September, Senators Phil Gramm, Warren Rudman, and Ernest Hollings offered an amendment to the debt ceiling bill to reform the budget process by forcing the Congress to achieve specific deficit reductions targets each year to eliminate the deficit by 1991. Early versions of the bill received considerable bipartisan interest from both Houses as well as from the White House. Many Members feared the political and economic consequences of increasing deficit spending, yet were unwilling to set automatic reductions in motion.

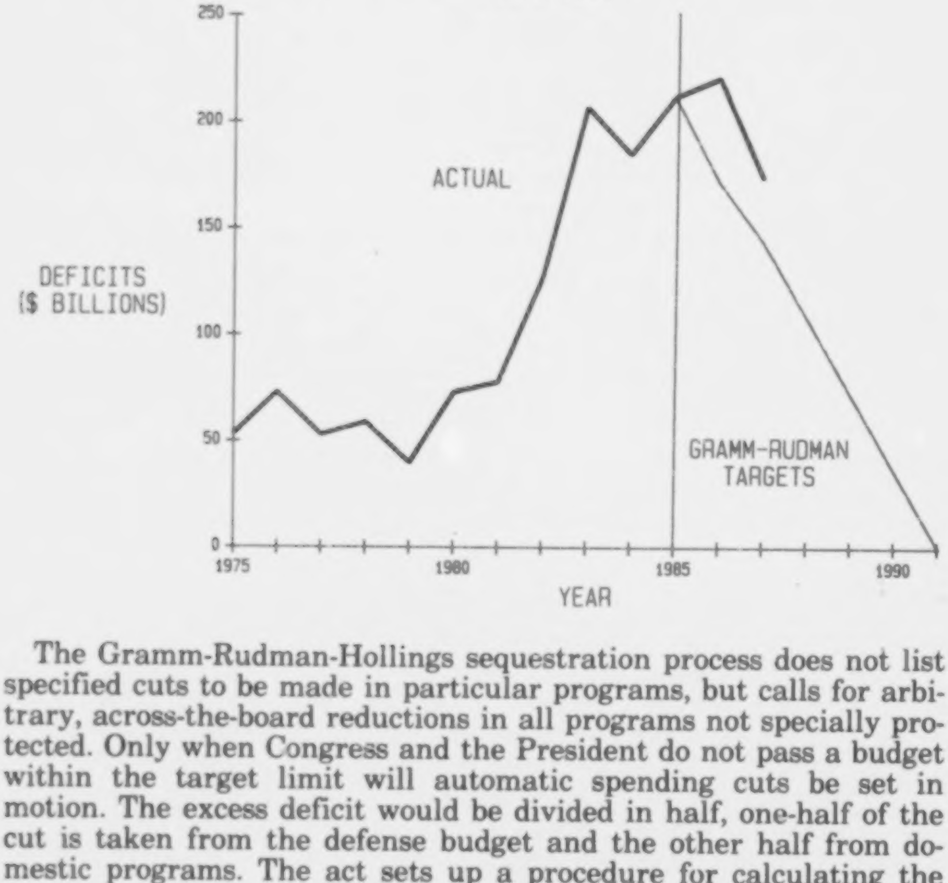
Gramm-Rudman-Hollings has a unique history in that it was not brought about through the usual committee channels. The debt-ceiling increase had first passed the House of Representatives on August 1. The Senate then added the budget balancing plan to the debt ceiling measure, and passed the package on October 10. The House went immediately into conference on the original debt ceiling measure alone, and the conferees disbanded in disagreement on October 31. The following day, the House voted for the revision worked out by the conferees, but the Senate again voted for its original plan, with few modifications, on November 6. A second conference devised the final version of the bill in a series of private meetings with House and Senate leadership. On December 11, 1985, Congress passed Gramm-Rudman-Hollings, and President Reagan signed the bill into law the next day.

2. Deficit Reduction Targets and Sequestration

Gramm-Rudman-Hollings provides for annual reductions in the budget deficit which was projected to reach $181.3 billion in fiscal year 1987. In moving toward the goal of $0 deficit by fiscal year 1991, it specifies deficit limits for each intervening year. In any year in which deficit limits are exceeded, the excess amount is to be automatically cut from the budget under a process known as sequestration. The act requires a $144 billion deficit cap for the current fiscal year, 1987. Current projections by the Congressional Budget Office indicate an additional $60 billion in deficit reduction will be required in the 1988 budget by October 15 of this year to prevent automatic cuts from being triggered. The deficit cap for 1988 is set at $108 billion.

CHART 13-1

FEDERAL DEFICITS UNDER GRAMM-RUDMAN
1975-1991



The Gramm-Rudman-Hollings sequestration process does not list specified cuts to be made in particular programs, but calls for arbitrary, across-the-board reductions in all programs not specially protected. Only when Congress and the President do not pass a budget within the target limit will automatic spending cuts be set in motion. The excess deficit would be divided in half, one-half of the cut is taken from the defense budget and the other half from domestic programs. The act sets up a procedure for calculating the resulting cuts in each program. The funds cut from each program must be taken from unobligated sources. Obligated funds cannot be cut because this would put the Government in a position of breaching numerous contracts and commitments.

3. BUDGET TIMETABLE

Gramm-Rudman-Hollings introduced substantial changes in both the mechanics and the theory of the budget process. The timetable for action has been compressed and considerably altered. The President submits his proposed budget to Congress early in the calendar year, with congressional committees to begin working on their own proposals shortly thereafter. A congressional budget resolution, the only one provided for under the act, is to be passed by April 15, with reconciliation legislation completed by June 15. House action on all annual appropriations bills, which by law originate in the House, is to be completed by June 30. Then, the many new procedures introduced by Gramm-Rudman-Hollings begin to come into play.

Using projections based on appropriations bills and other laws in effect at the time, the Director of the Office of Management and Budget [OMB] and the Director of the Congressional Budget Office [CBO] must issue a joint report August 20. This report estimates budget base levels, determining whether a deficit over the target limit will result from Congress' budget plans. If the deficit is projected to exceed the target level for that year, the report must also contain specific dollar figures as to how much money would need to be sequestered from the accounts of the various governmental agencies and departments in order to meet the target.

Under the law as originally written, OMB and CBO were to present their reports to the Comptroller General of the United States, the chief officer of the General Accounting Office [GAO]. The Comptroller General then was given 5 days in which to resolve differences between the OMB and CBO projections, and make his own report to the President and Congress as to the necessity for any sequestration. Based on this report, the act required the President to issure a sequestration order on September I, if sequestration is required. It is this section of the law which was struck down as unconstitutional by the Supreme Court (see section 3, below). Anticipating a constitutional challenge, the act contains fallback procedures under which Congress establishes a Temporary Joint Committee on Deficit Reduction (composed of the members of the Budget Committees of both Houses) to receive the reports from OMB and CBO. This Joint Committee is given 5 days to report out a joint resolution ordering the appropriate cuts which is then passed by both Houses and sent to the President.

After the sequestration amounts are calculated, Congress has the opportunity to come up with an alternative to the sequestration by passing a budget which meets the deficit targets. If it fails to do so, under the original provisions of the act, the Presidential order takes effect as of October 1, the start of the fiscal year, and funds are withheld as of the date. On October 5, a revised OMB/CBO report is to be issued which takes account of any legislative actions (such as tax bills or appropriations bills) which were taken after the first report was issued. On October 15, this final sequestration order issued by the President and based on the revised estimates, would take effect and sequestered funds would be permanently cancelled.

C. ISSUES

1. CONSTITUTIONALITY

The constitutionality of Gramm-Rudman-Hollings was challenged in a multiple-party lawsuit filed within hours of the law's passage. On February 7, 1986, a Federal district court found Gramm-

Rudman unconstitutional on the grounds that it vests executive power in the Comptroller General.[1] Since the Comptroller General is an official who is removable by Congress, the court reasoned that his actions are legislative in nature, and that the sequestration scheme violated the constitutional doctrine of separation of powers. The President's sequestration order for fiscal year 1986 remained in effect, while the case was appealed directly to the Supreme Court. (This expedited judicial procedure was provided for the act itself.) On July 7, 1986, the Supreme Court, in a 7 to 2 decision, declared section 251 of the Gramm-Rudman-Hollings Act unconstitutional.[2] Section 251 gave the Comptroller General the authority to direct the President to order sequestration. The Supreme Court agreed with the district court—Congress has no authority to execute laws, and therefore cannot empower its officer (the Comptroller General) to do so.

The striking down of section 251 triggered a fallback plan in the legislation. Under the provision, Congress receives the reports from OMB and CBO and then must pass a joint resolution to authorize the appropriate cuts. The $11.7 billion sequestration order for fiscal year 1986 was approved by Congress in this manner on July 17, 1986 (Public Law 99-366).

The result of the Supreme Court's decision is that Congress no longer has the threat of totally automatic reductions to spur it to action. If Congress itself does not take action, appropriate sequestrations will not occur. The reaffirmation of the 1986 cuts was seen by many Members as necessary to prove congressional commitment to deficit reduction. As the Gramm-Rudman-Hollings target become harder to meet, it is unclear whether Congress will be able to continue legislating substantial program reductions (or, in the alternative, revenue increases).

2. REDUCTIONS IN PROGRAMS AFFECTING THE ELDERLY

Gramm-Rudman-Hollings controls the funding for Federal programs in two ways. First, the deficit targets encourage Congress to reduce spending by cutting or even restructuring programs. Second, if targets are not met and sequestration is called for, programs benefitting senior citizens would be affected by the automatic cuts. The benefits paid under Social Security, railroad retirement tier I, Medicaid, Food Stamps, SSI, and veterans pensions are fully protected from sequestration. However, no such protection is given to the administrative costs of these programs, and there is a danger that the quality of service to the public might deteriorate.

The Federal civil service and military retirement programs, railroad retirement tier II and black lung disability, were originally subject to reductions up to the full amount of the annual cost-of-living adjustments [COLA's]. As directed by Gramm-Rudman, the 3.1 percent COLA's scheduled to go into effect January 1, 1986, were canceled under a Presidential sequestration order and reaffirmed by Congress after the Supreme Court decision. Subsequent legislation, however, has exempted these programs from further sequestrations.

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[1] *Synar* v. *United States*, 626 F. Supp. 1374 (1986).

[2] *Bowsher* v. *Synar*, 106 S.Ct. 3181 (1986).

Most health care programs including Medicare, Veterans' health care and community health centers would be subject to cuts in excess of inflation, but not more than 1 percent in fiscal year 1986 and not more than 2 percent in subsequent fiscal years. These programs were reduced by 1 percent in fiscal year 1986. Although benefits were not directly reduced, payments to health care providers were reduced, straining hospital resources. Further reductions in payment levels could result in reduced quality of care for Medicare and Medicaid beneficiaries.

Other domestic programs on which the elderly depend could be subject to unlimited across-the-board reductions based on a uniform percentage of current spending. When exempted and specially treated programs are removed from nondefense spending, approximately one-sixth of total outlays remains and these programs could face severe reductions. Programs which provide important services such as housing, low-income energy assistance, Older Americans programs, social services, transportation, health research into Alzheimer's and other diseases, block grants, and home weatherization projects were cut by 4.3 percent for fiscal year 1986.

In addition to cuts made according to OMB and CBO reports, all programs face possible reduction as part of congressional budgets designed to meet the deficit targets for a particular fiscal year. Future deficit targets drop sharply ($108 billion for 1988, $72 billion for 1989, $36 billion for 1990, and $0 in 1991), which could encourage Congress to scale back, or even eliminate, programs it has been committed to in the past.

D. BUDGET LEGISLATION

1. Fiscal Year 1986 Budget

The Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), as passed late in 1985, called for an $11.5 billion sequester of funds from the fiscal year 1986 budget. These funds were suspended by a Presidential order. Although the process of sequestration was declared partially unconstitutional by the Supreme Court in July 1986, the $11.7 billion of cuts were reaffirmed by a joint congressional resolution on July 17, 1986 (Public Law 99-366). The House of Representatives passed the measure by a vote of 339 to 72, while the Senate passed it by voice vote.

2. Fiscal Year 1987 Budget

(A) THE ADMINISTRATION'S PROPOSALS

The President's $994 billion budget request for fiscal year 1987 called for a 3-percent increase in defense spending and reductions in nearly all domestic programs other than Social Security. Proposals for programs effecting the elderly included:

—Providing full benefits (plus COLA's) to recipients of Social Security and veterans compensation and pensions;

—Eliminate 1987 cost-of-living adjustments for civil service, military and railroad retirement tier II benefits, and reduce increases for black lung beneficiaries;
—Reduce expenditures under the SSI and food stamp programs through tightened restrictions on eligibility;
—Increase Medicare beneficiaries' out-of-pocket expenses by $1.4 billion and reduce provider reimbursements by $2.7 billion for fiscal year 1987 (even more in later years);
—Cap Federal Medicaid payments to States, essentially altering the nature of the program from one which paid the medical bills of all who qualified for aid to essentially a State block grant program which would enable them to provide care only to the extent of available funds;
—Eliminate the Legal Services Corporation, the section 202 housing program for the elderly and handicapped, the home weatherization program, and the Community Services Block Grant program;
—Reduce expenditures for the National Institutes of Health, veterans health care, public housing, transportation, and certain social services; and
—Restore presequestration funding to the Low Income Home Energy Assistance Program, some Older Americans Act programs, Older American Volunteer programs, and the Equal Employment Opportunity Commission.

The request called for increased revenues from user fees, the sale of Government assets, and other mechanisms, but did not include increases in income tax revenues.

(B) THE FIRST CONGRESSIONAL BUDGET RESOLUTION

On March 24, 1986, the Senate Budget Committee reported the first concurrent budget resolution for fiscal year 1987. The proposal, offered by Chairman Domenici and Senator Chiles, passed the committee with broad bipartisan support. The resolution, S. Con. Res. 120, was developed as a middle ground among budget alternatives of sequestration and the President's budget request. The sponsors sought compromise between the President's insistence on large defense increases and refusal to consider tax increases, the indiscriminate cuts of Gramm-Rudman-Hollings sequestration which would make significant reductions in both domestic and defense programs, and the views of some that domestic programs must be spared at whatever cost. The Senate began consideration of S. Con. Res. 120 on April 21. On May 1 the Senate adopted an amended version of the resolution by a vote of 70 to 25.

The Senate resolution provided for significantly higher funding for many domestic programs than the President's fiscal year 1987 budget request. Lowered defense spending, higher revenues, and reestimate of inflation-mandated COLA's combined to allow the resolution to fund 42 domestic programs that the President would have eliminated, and maintain funding for others which the President would have significantly reduced. The resolution was more favorable to programs benefiting the elderly than the President's fiscal year 1987 budget request. S. Con. Res. 120 provided for full COLA's for all indexed retirement programs, even those which had lost their 1986 COLA to sequestration. The resolution contained no increases in Medicare beneficiary out-of-pocket expenses. Most other programs benefiting the elderly were funded at 1986 post-sequester levels.

The House Budget Committee reported out its own fiscal year 1987 budget resolution, H. Con. Res. 337, on May 13, 1986. A few attempts to amend the bill on the floor failed, and the House passed the measure by a vote of 245 to 179. The House then took up consideration of S. Con. Res. 120 and substituted its own language (the text of H. Con. Res. 337). A conference committee met to reconcile differences between the two Houses, filing its report on June 26, 1986. The House agreed to the conference report a vote of 333 to 43. The Senate passed it the next day by voice vote.

The provisions of the conference report on S. Con. Res. 120 were generally favorable to programs benefiting the elderly. The resolution provided for full inflation COLA's for all indexed Federal retirement programs, limited the growth of Medicare's hospital deductible, increased funding for the Low Income Home Energy Assistance Program, and funded most other programs benefiting the elderly at 1986 post-sequestration levels.

(C) FINAL BUDGET LEGISLATION

After the first concurrent budget resolution is passed, Congress begins its work on the 13 appropriation bills which, under the new Gramm-Rudman-Hollings timetable, are to be completed by June 30 of each year. As had been the case in past years, Congress had great difficulty in passing the appropriations bills in 1986. None of the 13 had been enacted by October 8. Five were in conference committees, 6 had not passed the Senate, and 2 had not yet even passed the House of Representatives (where these bills, by law, originate). Throughout October, 5 different continuing resolutions had been signed into law to keep the Government operating. Another continuing resolution had been vetoed by the President, causing Federal offices to close for an afternoon.

Unable to come to separate agreements on each of the appropriations bills, Congress wrapped them all into a continuing resolution signed October 18 (Public Law 99-500). Congress then quickly agreed to the Omnibus Budget Reconcilation Act of 1986 [OBRA], signed October 21 (Public Law 99-509).

Programs benefiting the elderly fair reasonably well under fiscal 1987 budget legislation. Full inflation COLA's (1.3 percent) were granted in all indexed Federal retirement programs—Social Security, SSI, Black Lung, and railroad, civil service and military retirement programs. For Medicare beneficiaries, OBRA raised the inpatient hospital deductible to $520 (an amount lower than would have gone into effect under current services estimates), reduced payments for cataract surgeries and allowed reimbursement for vision care services offered by optometrists. The bill raised the hospital prospective payment rates by 1.5 percent and provided for a two-tier increase in physician payments. The Federal Medicaid laws were amended to allow States to provide Medicaid coverage to the elderly and disabled (as well as pregnant women and infants) with incomes below the poverty line, but who do not qualify for SSI or

AFDC. The Food Stamp Program was fully funded to current services levels. Congress rejected administration proposals to eliminate most forms of housing assistance and to defer spending of fiscal year 1986 housing funds until fiscal year 1987. The Low Income Home Energy Assistance Program and Department of Energy's weatherization program were funded near 1986 post-sequester levels. Programs such as Legal Services Corporation and Community Services Block Grants were saved from administration proposals to eliminate them.

3. AMENDMENTS TO GRAMM-RUDMAN-HOLLINGS

(A) AMENDING THE PROCESS

After the Supreme Court declared a portion of the Gramm-Rudman-Hollings Act unconstitutional, its original sponsors sought to introduce amending legislation to solve constitutional difficulties without sacrificing the "automatic" element of sequestration. The original act had been introduced as an amendment to legislation increasing the allowable level of Federal debt for fiscal year 1986. Senators Gramm, Rudman, and Hollings offered what was dubbed "Gramm-Rudman-Hollings II" as an amendment to similar legislation for fiscal year 1987 (H.J. Res. 668).

This new legislative "fix" called for the OMB and CBO reports to be delivered to GAO, as under the original law. After GAO performed its auditing function, reconciling differences between the OMB and CBO figures, GAO would send its figures back to OMB for final certification. It was on the basis of these OMB "certified" numbers that the Presidential sequestration order would be issued. The sponsors promoted this mechanism as a way of avoiding constitutional separation of powers questions because the Comptroller General, an officer of Congress, would not be exercising powers reserved to the executive branch. Opponents feared the scheme would vest too much power in OMB, an agency whose predictions have come under congressional fire in the past.[3]

The "Gramm-Rudman-Hollings II" amendment passed the Senate on July 30, 1986, by a vote of 63 to 36. On August 9, the Senate passed the entire debt ceiling bill, with the amendment, by a vote of 47 to 40. H.J. Res. 668 then went to conference with the House, which had passed the original version of the bill on June 26 (without a Gramm-Rudman-Hollings fix). The agreement reached on the bill was not reported separately by the conferees, but put into the text of the year's reconciliation bill, the Omnibus Budget Reconciliation Act of 1986, which became law on October 21, 1986 (Public Law 99-509). This act did not contain provisions changing the Gramm-Rudman-Hollings reporting process, therefore "sequester" cuts will not happen automatically, but must be approved by congressional vote.

(B) EXEMPTING COST-OF-LIVING ADJUSTMENTS

The Omnibus Budget Reconciliation Act of 1986 also contained a provision to exempt from sequestration COLA's from those Federal retirement programs, including those for civil service and military retirement, black lung benefits, and railroad retirement tier II benefits. This language was added to the bill by the Senate by voice vote on September 19, 1986. Similar language had passed the House of Representatives as part of the freestanding bill, H.R. 4060, on June 24, 1986 by a vote of 396 to 19. The amendment language became part of the House and Senate conference agreement, adopted by both Houses and eventually signed into law on October 21, 1986.

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[3] For the full debate, see: Congressional Record, v. 131, July 30, 1986.

This law prevents further automatic cancellation of COLA's under sequestration, but is not a safeguard against any COLA reduction. Congress retains the power to reduce or eliminate COLA's in these and other retirement programs as part of budgets designed to meet the Gramm-Rudman-Hollings targets through fiscal year 1991.

In addition, the Omnibus Budget Reconciliation Act of 1986 was amended in the Senate to provide that railroad retirement vested dual benefits were exempt from any reductions. These benefits, which are not indexed to inflation, were not specially protected by Gramm-Rudman-Hollings and benefits were actually reduced by sequestration in 1986.

E. PROGNOSIS

The Gramm-Rudman-Hollings Act, even though declared partially unconstitutional, has had a profound effect on the Federal budget process. Although actual deficits have risen higher than the targeted amounts for fiscal years 1986 and 1987, deficit growth has been slowed somewhat and congressional leaders are commiting themselves to reducing Federal deficit, but whether in future years they would make cuts in programs such as Social Security or raise taxes against the will of the President remains to be seen.

One of the purposes of Gramm-Rudman-Hollings is to force Congress to enact legislation in advance of sequestration which meets the deficit targets. Budgets which do fulfill this requirement in fiscal years 1987 and beyond are certain to contain some cuts in programs for senior citizens, the character of those cuts is impossible to predict at this time. Programs exempt or specially treated in the sequestration process are not protected from change as part of congressional legislation, they are only guaranteed safe from the automatic sequestration designed to be the last resort.

SUPPLEMENTAL MATERIAL

Supplement 1

1986 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

THE EFFECTS OF PPS ON QUALITY OF CARE FOR MEDICARE PATIENTS, LOS ANGELES, CA, JANUARY 7, 1986, HON. PETE WILSON, PRESIDING

WITNESSES

Eva Skinner, R.N., California Medical Review, Inc., and member of the Gray Panthers National Advisory Board, Los Angeles, CA.

Jack Gould, Los Angeles, CA.

Bartlett Fleming, Associate Administrator for Management and Support Services, HCFA, Washington, DC.

William H. Moncrief, Jr., M.D., President, California Medical Review, Inc., San Francisco, CA.

Sam Tibbitts, President, Lutheran Hospital Systems Corp., Los Angeles, CA.

Kendall Phelps, Administrator, The French Hospital Health Plan, San Francisco, CA.

Joseph Barbaccia, M.D., Specialist in Geriatric Care, University of California at San Francisco Medical School, San Francisco, CA.

Robert Reid, M.D., Community Practitioner, San Jose, CA.

Patricia Worthen, Discharge Planner, Good Samaritan Hospital, Los Angeles, CA.

Sharon Grigsby, President, The Visiting Nurses Association of Santa Monica, Santa Monica, CA.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to discover the extent of quality of care problems under Medicare's Prospective Payment System [PPS]. It looked into the entire continuum of care, from acute care to nursing homes to home health care.

According to a 6-month investigation conducted by the Aging Committee into the implementation of Medicare's Prospective Payment System there have been serious implications for Medicare patients as some hospitals try to contain uncompensated care costs by releasing patients inappropriately or prematurely when the Diagnostic Related Group [DRG] allocation expires.

How extensive are these problems? Existing Medicare data do not allow a precise answer to be given. There are, however, significant indications that these problems are more severe and widespread than current HCFA estimates based upon the very limited information available from Medicare's PRO's, would indicate. The Health Care Financing Administration has focused the PRO's on a very narrow and incomplete set of quality issues, and therefore HCFA's assessment of quality of care is seriously deficient.

Dr. William H. Moncrief, speaking on behalf of the California Medical Review Association, testified that there are some organizations "where it appears to be a corporate policy to keep the hospital stay as short as possible." He further stated that the scope of Peer Review Organizations needs to be expanded to include postacute hospital quality review. According to Dr. Moncrief, the largest problems with the Prospective Payment System is that there is a void in the policy for the terminally ill.

GRAMM-RUDMAN-HOLLINGS: THE IMPACT ON THE ELDERLY, WASHINGTON, DC, FEBRUARY 21, 1986, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

T. Franklin Williams, M.D., Director, National Institute on Aging, National Institutes of Health, Bethesda, MD.

John J. Knapp, Acting Under Secretary, Department of Housing and Urban Development, Washington, DC.

Bartlett S. Fleming, Acting Deputy Administrator, Health Care Financing Administration, Department of Health and Human Services, Washington, DC.

Nelson J. Sabatini, Acting Deputy Commissioner for Management and Assessment, Social Security Administration, Baltimore, MD.

John H. Mather, M.D., Assistant Chief Medical Director for Geriatric and Extended Care, Veterans Administration, Washington, DC.

Michio Suzuki, Associate Commissioner for State and Tribal Programs, Administration on Aging, Department of Health and Human Services, Washington, DC.

Shauna O'Neil, President, National Association of Area Agencies on Aging, Representing the Leadership Council of Aging Organizations, Salt Lake City, UT.

L.J. Andolsek, President, National Association of Retired Federal Employees, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was held to enlighten the Congress as to how the agencies that manage the various programs for the aging intend to implement the budget cuts which were effected with the implementation of the Gramm-Rudman-Hollings Act. Officials from the Department of Housing and Urban Development, National Institute on Aging, National Institutes of Health, Health Care Financing Administration, Social Security Administration, Veterans Administration, and the Administration on Aging were invited to testify on how their agencies intend to absorb the budget cuts and how it would effect the services they provide.

The way the act is written, the sequestration is done across-the-board by line item. This limits agency discretion as to where to reduce funding or cut programs. Generally, instead of canceling programs, the reductions are coming from administrative budgets and funding for new projects. It was brought out in the hearing that this approach to fiscal reductions has some negative repercussions.

For example, by Medicare cutting administrative expenditures, the processing of claims is being slowed down. According to Bart Fleming, the money HCFA makes in interest on these delayed payments would make up for the funds lost by the budget cut. However, this may create serious problems for Medicare beneficiaries and providers of Medicare services.

Reducing funding for new projects or expansion of current programs when the beneficiary population is growing creates the problem of people not receiving the services they qualify for and need. The Department of Housing and Urban Development will reduce construction of all types of new public housing facilities as well as reducing the use of other sources, such as the voucher program. Although this will not affect those people who are currently living in HUD facilities or participating in the voucher program, it can be anticipated that the shortage of public housing that now exists will become more critical as the need for these services increases while availability decreases.

DISPOSABLE DIALYSIS DEVICES: IS REUSE ABUSE? WASHINGTON, DC, MARCH 6, 1986, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Melinda McFadden, Philadelphia, PA.
Vagn Vogter, St. Petersburg, FL.
Malcolm Shuman, Baton Rouge, LA.
Robert Rosen, Bensalem, PA.
James R. Beall, Ph.D., Board Certified Toxicologist, Gaithersburg, MD.
Charles J. Wolf, M.D., Head, Section on Renal Diseases, Pennsylvania Hospital, Philadelphia, PA.
Terry D. Oberley, M.D., Associate Professor of Pathology, University of Wisconsin Medical School, Madison, WI.
John E. Marshall, Ph.D., Director, National Center for Health Services Research, and Health Care Technology Assessment, Public Health Service, Rockville, MD.
Bartlett Fleming, Acting Deputy Administrator, Health Care Financing Administration, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was the result of a 4-month committee investigation into the safety and efficacy of the current practice of reusing disposable dialysis devices in the treatment of end stage renal disease. According to the staff report, more than 60 percent of dialysis clinics reuse filters up to 30 times, which creates a financial windfall for these clinics of $80 million per year in excess profits through reuse of the filters alone. The reuse of these devices exposes the dialysis patients to dangerous and unnecessary risks including formaldehyde poisoning which can result in cancer, liver damage, and destruction of red blood cells.

In 1978, Congress mandated a study by the National Institutes of Health into the reuse of dialyzers to determine the safety of this practice. At the time of this hearing, NIH had not yet delivered a final report to the Congress. The Health Care Financing Administration and the Food and Drug Administration, who have regulatory responsibility for dialysis, have both backed off of the issue of potential risks to patients who receive treatment with reused devices. These agencies were asked to testify as to why they have been so inactive and unresponsive in this matter.

EMPLOYMENT OPPORTUNITIES FOR WOMEN: TODAY AND TOMORROW, APRIL 21, 1986, CLEVELAND, OH, HON. JOHN GLENN, PRESIDING

WITNESSES

Harvey L. Sterns, Ph.D., Associate Professor of Psychology, University of Akron; Director, Institute for Life-Span Development and Gerontology; Research Associate Professor of Gerontology in Community Health Science, Northeastern Ohio Universities College of Medicine, Akron, OH.

Audrey J. Spencer, Executive Director, Western Reserve Area Agency on Aging, Cleveland, OH.

Bobbi Presley, Director of Women's Program, Cuyahoga Community College, Cleveland, OH.

Cathie Collins, Student, Cuyahoga Community College and Member, Displaced Homemakers Program, Berea, OH.

Marge Butera, Manager of Rehabilitation Vocational Guidance Services and Former Director of Skills Available, Cleveland, OH.

Mary Williams, Nursing Assistant and Participant of Vocational Guidance Services', Skills Available Program, Cleveland, OH.

Phoebe Bailey, Preretirement Planner, American Association of Retired Persons, Massapequa, NY.

Wilma R. Combs, Chief of Small and Disadvantaged Business Utilization, Defense Contract Administrative Services Region, Shaker Heights, OH.

Lois Goodman, Manager, Career Development AmeriTrust Co., Cleveland, OH.

Zev Harel, Ph.D., Director, Center on Applied Gerontological Research, Cleveland State University, Cleveland, OH.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was called by Senator Glenn as the last in a series of four hearings dealing with women in our aging society. The focus of this hearing was employment and retirement problems for women—problems arising when women have to re-enter the workforce to support their families, and provide for themselves in retirement.

Witnesses in the hearing brought forth relevant personal experiences and enlightened the committee about work and retirement policies which have created the biases faced by many women. They revealed the myriad of obstacles a woman reentering the workforce must face. Often, without a marketable skill and no available training, women are forced to accept poor paying positions which will further hurt them when retirement income is needed.

Further testimony described programs such as the Displaced Homemakers Program and the Federal Government's Job Training Partnership Act which have been developed to provide individuals with the support and vocational training necessary to obtain a good position. Some companies and organizations like AARP have established preretirement counseling programs to help both women and men alike prepare for retirement in terms of finances as well as the change in lifestyle. For older workers, the Federal Government has set up the Senior Community Service Employment Program, or title V, which provides senior citizens with part-time work to supplement their Social Security income. While these programs provide a necessary service, changes are needed in our work and retirement policies to benefit women.

THE EROSION OF THE MEDICARE HOME HEALTH CARE BENEFIT, APRIL 21, 1986, NEWARK, NJ, HON. BILL BRADLEY, PRESIDING

WITNESSES

Geoffrey Perselay, Acting Commissioner, New Jersey Department of Human Services, Trenton, NJ.
Hon. Peter Shapiro, County Executive, Essex County, Newark, NJ.
Edith Edelson, Cochairman, New Jersey Home Health Care Coalition, New Brunswick, NJ.
Delores Higham on behalf of Helen Kennedy, Hamilton Square, NJ.
Katherine Trimble, Paramus, NJ.
Patricia Roy on behalf of Agnes Kelly, Turnersville, NJ.
John Paul Marosy, Executive Director, Home Health Agency Assembly of New Jersey, Inc., Newark, NJ.
James Schuessler, President and Chief Executive Officer, Community Memorial Hospital Health Services Corp., Toms River, NJ.
Elana Zucker, Director of Community Health Services, Overlook Hospital, Summit, NJ.
Marilyn Zuchowski, Executive Director, Somerset Valley Visiting Nurses Association, Bridgewater, NJ.
Lois Hull, Director, Essex County Division on Aging, East Orange, NJ.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to look into the ability of the Medicare Home Health Care benefit to adequately provide for beneficiaries who, under the new Prospective Payment System, have been discharged from the hospital in greater need of postacute care, as well as the need for Medicare to provide for community-based long-term care.

Although home health care only amounts to 2 to 3 percent of the Medicare budget, according to Mr. Perselay, it appears that the Health Care Financing Administration has directed its fiscal intermediaries to force cutbacks by shifting these costs to providers, the States, and to the infirmed themselves. This is being done by limiting patient access to home health care and denying reimbursement for claims. The situation is further complicated because HCFA had been changing the eligibility guidelines without adequately informing home health care providers.

NURSING HOME CARE: THE UNFINISHED AGENDA, WASHINGTON, DC, MAY 21, 1986, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

William R. Roper, M.D., Administrator, Health Care Financing Administration, HHS, Washington, DC.
Dorothy Doyle, Alpharetta, GA.
Peggy Dowling, Napa, CA.
Ralph Lopez, Chief, Health Facilities Division, Department of Health Services, Los Angeles, CA.
Sandra K. Casper, President, Rehabilitation Care Consultants, Madison, WI.
Conrad Thompson, Director, Washington Bureau of Nursing Home Affairs, Olympia, WA.
Toby Edelman, Staff Attorney, National Senior Citizens Law Center, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was the result of a 2-year committee investigation into the quality of care provided to patients in nursing homes. Findings of the investigation included: (a) Almost one-third of the Nation's 8,852 skilled nursing facilities failed to meet at least one basic Federal standard in 1984; (b) almost 1,000 failed to meet three or more such standards; (c) a substantial number of these homes are chronic offenders; (d) there has been a 75-percent increase in failure to provide physician supervision for patients; (e) there has been a 61-percent increase in failure to provide 24-hour nursing care. Despite the high number of violations, the Federal Government claims to have decertified only 200 nursing homes in 1985.

Dr. Roper was called upon to testify regarding the failure of HCFA to adequately enforce nursing home regulations. Dr. Roper explained that the problem HCFA is facing is that to decertify facilities when there is already a serious shortage of nursing home beds for Medicaid patients will only exacerbate the problem. Suggestions were made that HCFA develop a system of intermediate sanctions which would punish those facilities that did not meet Federal standards without stripping them of their Medicaid certification.

Dorothy Doyle and Peggy Dowling described their families experiences with substandard nursing homes. Other testimony illustrated a successful quality standard enforcement program in Los Angeles County, CA, and outlined the magnitude of the problem, both in the field and within HCFA.

MEDICARE: OVERSIGHT ON PAYMENT DELAYS, MAY 23, 1986, JACKSONVILLE, FL, HON. LAWTON CHILES, PRESIDING

WITNESSES

Susan H. Keller, Daytona Beach, FL.
Mrs. Myer de Leeuwe, Daytona Beach, FL.
Clyde Herzog, Jacksonville, FL.
William J. Garoni, M.D., Florida Medical Association, Jacksonville, FL.
Ignacio Arjona, President, Dade County Medical Rental and Sales, Inc., Miami, FL.
Antonio Favino, Senior Vice President for Operation, Blue Cross and Blue Shield of Florida, Inc.
Alan Spielman, Executive Director, Federal Financing and Tax Legislation, National Blue Cross and Blue Shield Association, Washington, DC.
George Holland, Regional Administrator, HCFA, Department of Health and Human Services, Atlanta, GA.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was convened by Senator Chiles to look into the reasons for the dramatic increase in Medicare payment delays. The Health Care Financing Administration has intentionally slowed the processing of Medicare claims in order to save money for the trust fund. In addition to that, fiscal intermediaries have suffered a Gramm-Rudman-Hollings recision of 4.3 percent.

In real terms, according to Blue Cross and Blue Shield, this translates into an increase in the end of the year claims backlog of 266 percent from fiscal year 1983 to fiscal year 1986. Mr. Spielman testified that Blue Cross and Blue Shield has the ability to process all claims in a more expedient manner if they were funded properly. However, even if they could turn around a claim in 1 day, HCFA will not let them send out the check immediately.

Medicare beneficiaries and physician providers explained the frustration and the financial burden placed on them by this delay. When payment is delayed by several months, many physicians who accept assignment for a large number of their Medicare patients find themselves in a severe cash-flow crisis. Beneficiaries who are not taken on assignment by their physicians are thrust into a bureaucratic nightmare as they try to expedite the processing of their claims while their past-due doctor's bills pile up.

WORKING AMERICANS: EQUALITY AT ANY AGE, JUNE 19, 1986, WASHINGTON, DC, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

U.S. Congressman Claude Pepper, Florida, 18th District.
Victor Steigerwald, Pittsburgh, PA.
Solomon Levine, Bridgeport, CT.
J. Wolfgang Granat, Philadelphia, PA.
Vincent Gallagher, M.D., Corporate Medical Director, Grumman Corp., Bethpage, NY.

Mark A. de Bernardo, Labor Law Manager, U.S. Chamber of Commerce, Washington, DC.

Raymond C. Fay, Attorney, Law Offices of Haley, Bader and Potts, Washington, DC.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing looked into the issue of lifting the age 70 retirement cap for workers. There are 1.2 million Americans age 70 and over in the work force. Many of these people want to continue working—sometimes for reasons of self-fulfillment, but more often for reasons of economic necessity. Many more older Americans would like to continue to work after age 70, but are forced to retire. Wolfgang Granat, violist for the Philadelphia Orchestra, testified about his deep desire to continue working, and fear of being forced to retire on his 70th birthday. Victor Steigerwald explained how he truly enjoys his work and depends on the income.

Almost half of all larger companies already realize the value of their older workers and have voluntarily eliminated mandatory retirement. A recent Department of Labor study found that abolishing the mandatory retirement age would have no significant adverse impact on other segments in the labor force, such as youth, women and minorities. Allowing older people to remain productive will also lessen the strains on our retirement income programs. According to figures from the Social Security Administration, the elimination of mandatory retirement would save the OASDI trust fund \$0.7 billion annually by the year 2000 and \$4 billion annually by the year 2020.

THE OLDER AMERICANS ACT AND ITS APPLICATION TO NATIVE AMERICANS, JUNE 28, 1986, OKLAHOMA CITY, OK, HON. DON NICKLES, PRESIDING

WITNESSES

Rudy Cleghorn, Otoe-Missouria Tribe, Oklahoma Indian Council on Aging, Red Rock, OK.

John Diaz, Regional Program Director, Administration on Aging, Region VI, Dallas, TX.

Jeannie Lunsford, Commissioner, Oklahoma Indian Affairs Commission, the Chickasaw Nation, Ada, OK.

Steve Wilson, Manager, Community Research and Development Administration, Muscogee Creek Nation, Okmulgee, OK.

Paul Stabler, Executive Coordinator, Tulsa Area Agency on Aging, Tulsa, OK.

Pat Woods, Administrative Officer of the Chickasaw Nation of Oklahoma, Ada, OK.

Elizabeth White, Program Manager, Yakmia Indian Nation Area Agency on Aging, Chairperson, National Association of title VI Grantees and Indian Area Agencies on Aging, Toppenish, WA.

Barbara Yee, Ph.D., School of Human Development, University of Oklahoma, San Jose, CA.

Oneida Samis, Title VI Program Director, Choctaw Nation of Oklahoma, Durant, OK.

Randle Durant, Choctaw Tribal Councilman, Durant, OK.

Curtis Cook, National Indian Committee on Aging, Albuquerque, NM.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing looked into the extent to which the Older Americans Act programs are providing needed services to elderly Native Americans. Elderly Indians can qualify for nutrition and social services under title VI of the Older Americans Act. Title VI addresses the specific needs of the Indian population and is administered to the elderly by the tribes themselves.

Testimony developed the point that there are serious coordination problems between administering title III and title VI services which causes many Indian elderly to fall through the cracks. Title VI programs for Native Americans amounts to approximately 1 percent of the total budget for Older Americans Act programs. Sixty percent of the workers for title IV programs are volunteers. Despite the concerted efforts of the tribes to economize, the funding for title IV does not adequately cover the need for services. An example of the coordination difficulties faced by elderly Indians is that in order to obtain health and medical services, they must move into the towns. However, under title VI, people who live in towns with population of 10,000 or more cannot qualify for title VI nutrition services. Another issue discussed related to the need for a more responsive Administration on Aging. One possible solution discussed would be to have an Indian desk at the Administration of Aging headed by an American Indian.

PROVIDING A COMPREHENSIVE AND COMPASSIONATE LONG-TERM CARE PROGRAM FOR AMERICA'S SENIOR CITIZENS, NEW HAVEN, CT, JULY 7, 1986, HON. CHRISTOPHER J. DODD, PRESIDING

WITNESSES

Dorothy Kelly, Hamden, CT.

Mary Ellen Klinck, Commissioner, Connecticut Department on Aging, Hartford, CT.

Adrian M. Ostfeld, M.D., Professor of Epidemiology and Public Health, Yale University School of Medicine, New Haven, CT.

Audrey M. Wasik, Coordinator, Connecticut Commission on Long-Term Care, Hartford, CT.

Elizabeth A. Daubert, Executive Director, The Connecticut Association for Home Care, Inc., Wallingford, CT.

Joan Quinn, President, Connecticut Community Care, Inc., Bristol, CT.

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Dodd convened this hearing to examine the availability and quality of existing home and community-based long-term care services, as opposed to institutional long-term care. Professor Ostfeld, citing the results of a study conducted in New Haven, CT, stated that 1 out of 4 older persons live alone and will predictably require some form of long-term care. This care need not be "for life," however, as 3 out of 4 of the people in the study who were disabled in 1 year were either partially or completely recovered from that disability in the following year. Most of these older people would prefer to remain independent and in their own home, and could do so if provided with adequate support services.

Further testimony developed the point that although virtually every town in Connecticut has some type of community-based long-term care service provider, there remain substantial problems in the coordination of these services. According to Elizabeth Daubert, the most critical shortage is in the area of social support services, such as homemaker and chore services. Ms. Daubert testified that the reason there are unmet needs in the social services provided to senior citizens is that there is a lack of sufficient public and private funds to pay for these services.

The funding of community-based long-term care services has become a greater concern since the implementation of the Medicare prospective payment system (PPS). PPS encourages hospitals to discharge patients as earlier than in the past. As a result, these patients frequently are not fully recovered and require continued health care services. For many patients, these services are either not adequate or not available due to the lack of available funding for necessary post-hospital services, such as home health care.

THE CRISIS IN HOME HEALTH CARE: GREATER NEED, LESS CARE, JULY 28, 1986, PHILADELPHIA, PA, HON. JOHN HEINZ, PRESIDING

WITNESSES

Florence Bodie, Wilkes-Barre, PA.
John Schuh, Uniontown, PA.
Harvey Simms, Freeland, PA.
Harry Welling, Connellsville, PA.
Gerald Shuttlesworth, Chief Executive Officer, Albert Gallatin Visiting Nurse Association, Masontown, PA.
Sharon Mey, Finleyville, PA.
Rosemary Jenkins, Belle Vernon, PA.
Catherine Frasca, Executive Director, South Hills Health Systems, Pittsburgh, PA.
Marilyn Koch, Acting Regional Administrator, Health Care Financing Administration, Philadelphia, PA.
Thomas McElvogue, Vice President, Government Relations and Special Projects, Blue Cross of Greater Philadelphia, Philadelphia, PA.

ISSUES RAISED AND TESTIMONY SUMMARY

Since implementation of Medicare's Prospective Payment System in 1984, hospital discharges to home health care services have increased by 37 percent. At the same time, home health care denials have increased 164 percent. Of these denials, 21 percent are reversed when the fiscal intermediary is asked to reconsider them, 55 percent are reversed when brought before an Administrative Law Judge. This results in an overall reversal rate of 23 percent.

The purpose of this hearing was to illustrate the need for increased Medicare home health benefits, and to determine why the program is being administered in such an inconsistent manner. The first five witnesses were home health care beneficiaries and, as they are home-bound, appeared via video tape. Although they met all of the statutory and regulatory criteria for qualifying for home health benefits, they were nonetheless denied this care. Mrs. Mey and Mrs. Jenkins, who both cared for their very ill fathers in their homes, related their experiences with the home health benefit.

Kathy Frasca, a recognized expert in the field of home health care, testified that her agency, which had formerly been cited as exemplary, received denials of payment for 657 patients from September 1985 to April 1986. Mrs. Frasca went on to explain that home health care providers no longer are certain about what services are or are not covered by Medicare as HCFA has been changing the regulations with unpublished notices. Furthermore, analysis of testimony by Mrs. Koch shows that HCFA has built into the claims review process certain incentives for denial of home health care claims.

RETIREE HEALTH BENEFITS: THE FAIR WEATHER PROMISE? AUGUST 7, 1986, WASHINGTON, DC, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

WITNESSES

Lillian Grimaldi, Norwalk, CT.
Gerald and Sylvia Taylor, Aliquippa, PA.
Leonard Harris, Dayton, OH.
Neal S. Dudovitz, Deputy Director, National Senior Citizens Law Center, Los Angeles, CA.
Willis B. Goldbeck, President, Washington Business Group on Health, Washington, DC.
Douglas G. Baird, Professor of Law, University of Chicago Law School, Chicago, IL.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was held to look into the problems faced by retirees when their companies, for reasons such as bankruptcy or plant closings, terminate their health insurance coverage. All too frequently, people who are old enough to retire but not old enough to qualify for Medicare, find themselves unable to obtain other health insurance coverage at affordable premiums. For persons with preexisting health conditions, coverage may be unobtainable at any price. In cases like that of Mr. Harris, some simply deny themselves necessary health care for fear of not being able to pay for it.

Employers contractual obligation to continue to provide such benefits is in doubt. Courts have focused on the extent to which employers have indicated an irrevocable promise of these benefits to retirees. As court decisions define the permanence of retiree health benefits in terms of the language used when the promise is made, there is increasing concern that employers will explicitly reserve the right to revoke this promise, leaving the reliability of these benefits in doubt for future retirees.

Attention was focused on the stability of these benefits in bankruptcy with the recent attempt of LTV Corp. to terminate health benefits for retirees as part of their declaration of bankruptcy. Professor Baird explained that strengthening retirees claims to health benefits in bankruptcy will not solve the problem as many companies discontinue these benefits outside of bankruptcy proceedings.

HEALTH CARE FOR OLDER AMERICANS: INSURING AGAINST CATASTROPHIC LOSS, AUGUST 27-28, 1986, FORT SMITH, AR AND LITTLE ROCK, AR, HON. DAVID PRYOR, PRESIDING

WITNESSES

August 27, Fort Smith, AR

Jim, Medley, President, Arkansas Home Health Association, Fort Smith, AR.
Nelma Bennett, R.N., Logan County Nursing Supervisor, Area Agency on Aging of Western Arkansas, Paris, AR.
Sarah Lovett, Greenwood, AR.
Sam Hocutt, Hot Springs, AR.
Pat Phillips, M.D., Council Member, 10th District, Arkansas Medical Society, Fort Smith, AR.
James McDonald, President, Arkansas Hospice Association, Fayetteville, AR.
Robert T. Lane, CLU, CHFC, National Committeeman, Arkansas State Association of Life Underwriters, Fort Smith, AR.

August 28, Little Rock, AR

Robert M. Eubanks III, Commissioner, Arkansas Insurance Department.
Ron Sheffield, Assistant Commissioner for Consumer Affairs, Arkansas Insurance Department.
George K. Mitchell, M.D., President, Blue Cross and Blue Shield for the State of Arkansas.
Dewey Lantrip, Volunteer, AARP State Legislative Committee, AARP State Health Care Coordinator, Member of the Governor's Advisory Council on Aging.
Beth Smith, Ph.D., Associate Director, Health Services Research and Development Field Program, VA Medical Center, Little Rock, AR.
David Lipschitz, M.D., Ph.D., Director of Geriatric Research and Development Field Program, VA Medical Center, Little Rock, AR.
David Clark, Mineral Springs, AR.
Herb Sanderson, Director, Office of Aging and Adult Services, Arkansas State Department of Human Services.
Roger Busfield, M.D., Director, Arkansas Hospital Association.
Dixie Dugan, Executive Director, Central Arkansas Area Agency on Aging.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to explore the definition of catastrophic illness, as well as suggestions for policy which would offer some insurance coverage for catastrophic illness. The problem of catastrophic illness has been defined in terms of expense rather than the degree of illness. According to Mr. Sanderson, "More people now die of chronic than acute illnesses."

According to Dr. Busfield, the three causes of catastrophic expenses for health care are: "One, inadequate Medicare coverage of catastrophic acute care costs. Two, even more inadequate public and private coverage of long-term care costs; and, third, the presence of large numbers of uninsured and underinsured in the non-Medicare population." A number of possible solutions were suggested, including: Regulated Medi-Gap policies, Individual Medical Accounts which would be set up in a similar fashion to Individual Retirement Accounts and would be used as financial protection against catastrophic, acute and long-term care costs, and expanding the Medicare Program to include coverage for unlimited days of acute care as well as long-term care coverage.

THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS, SANTA FE, NM, SEPTEMBER 3, 1986, HON. JEFF BINGAMAN, PRESIDING

WITNESSES

Curtis Cook, Executive Director, National Indian Council on Aging, Albuquerque, NM.
Alcario Chavez, Lieutenant Governor of Sandia Pueblo, Bernalillo, NM.
James Hena, representative, Eight Northern Indian Pueblo Council, Sante Fe, NM.
Ron Tso, Acting Deputy Director, Division of Health Improvement Services, Navajo Nation, Window Rock, AZ.
Evelyn Breuninger, Secretary, Mescalero Apache Tribal Council, Mescalero, NM.
Richard Kozoll, M.D., Health Services Divison, New Mexico Health and Environmental Department, Sante Fe, NM.
Emily Velasquez, Director, Title VI Program, Isleta Pueblo, NM.
Mary L. Brueggeman, Administrator, Rehoboth McKinley Christian Home Health Services, Gallup, NM.
T.D. Smith, Executive Director, Laguna Rainbow Corp., New Laguna, NM.
Richard A. Kalish, Ph.D., Social Psychologist and Social Gerontologist, Santa Fe, NM.
George Buzzard, Acting Associate Director, Office of Planning, Evaluation, and Legislation, Indian Health Service, Rockville, MD.
Robert Carr, Director of Social Services, Bureau of Indian Affairs, Albuquerque, NM.
Daniel F. Bonner, Associate Director, Domestic and Anti-Poverty Programs, ACTION, Washington, DC.
Rafael Mecham, Director, Office of Indian Programs, HUD, Phoenix, AZ.
Gene Dickey, Regional Administrator, Food and Nutrition Services, U.S. Department of Agriculture, Dallas, TX.
Regis Pecos, Executive Director, New Mexico Office of Indian Affairs, Sante Fe, NM.
Catherine Salveson, Program Unit Supervisor, New Mexico State Agency on Aging, Santa Fe, NM.
Larry Curley, Consultant, Albuquerque, NM.
Paul Nathanson, Director, Institute of Public Law, University of New Mexico, Albuquerque, NM.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to review State, Federal, and tribal health care resources available to the Indian elderly. It examined that continuum of care, from health promotion and disease prevention to home health care and nursing home care. Testimony was heard from senior representatives of various Native American tribes, service providers, and representatives of State and Federal programs and agencies.

According to the U.S. Census Bureau, the average life expectancy for the Indian population is 8 years shorter than that of the rest of the population. Studies by the National Indian Council on Aging show that the Indian elderly live in poor housing and poor health. The Departments of Health and Human Services (including the Indian Health Service), Housing and Urban Development, and Agriculture, as well as the Bureau of Indian Affairs and the ACTION agency testified regarding Federal programs established to provide health care to the Indian population. However, much of the testimony indicated serious problems regarding the accessibility and utilization of many of these programs. There is a serious lack of health care facilities on reservations. The lack of transportation poses major barriers to the limited services and facilities that do exist. Numerous recommendations were presented pertaining to improved Federal coordination of services for Indian elders, the development of a national policy for Indian elders, and significantly improved health care services particularly on reservations and in isolated rural areas.

Supplement 2

COMMITTEE PRINTS AND REPORTS PRINTED BY THE SPECIAL COMMITTEE ON AGING IN 1986

Protecting Older Americans Against Overpayment of Income Taxes, committee print, Serial No. 99-F, January 1986.

The Cost of Mandating Pension Accruals of Older Workers, committee print, Serial No. 99-G, February 1986.

The Impact of Gramm-Rudman-Hollings on Programs Serving Older Americans: Fiscal Year 1986, committee print, Serial No. 99-H, February 1986.

Alternative Budgets for Fiscal Year 1987: Impact on Older Americans, committee print, Serial No. 99-I, May 1986.

Nursing Home Care: The Unfinished Agenda, committee print, Serial No. 99-J, May 1986.

Hazards in Reuse of Disposable Dialysis Devices, committee print, Serial No. 99-K, October 1986.

The Health Status and Health Care Needs of Older Americans, committee print, Serial No. 99-L, October 1986.

A Matter of Choice: Planning Ahead for Health Care Decisions, committee print, Serial No. 99-M, December 1986.

Hazards in Reuse of Disposable Dialysis Devices—Appendix, committee print, Serial No. 99-N, December 1986.

Developments In Aging: 1985—Volume 1, Report No. 99-242, February 1986.

Developments In Aging: 1985—Volume 2—Appendixes, Report No. 99-242, February 1986.

Developments In Aging: 1985—Volume 3—America In Transition: An Aging Society, Report No. 99-242, February 1986.

Supplement 3

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REPORTS AND COMMITTEE PRINTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.**

Developments in Aging, 1963 and 1964, Report No. 124, March 1965.**

Developments in Aging, 1965, Report No. 1073, March 1966.**

Developments in Aging, 1966, Report No. 169, April 1967.**

Developments in Aging, 1967, Report No. 1098, April 1968.**

Developments in Aging, 1968, Report No. 91-119, April 1969.**

Developments in Aging, 1969, Report No. 91-875, May 1970.**

Developments in Aging, 1970, Report No. 92-46, March 1971.**

Developments in Aging: 1971 and January-March 1972, Report No. 92-784, May 1972.**

Developments in Aging: 1972 and January-March 1973, Report No. 93-147, May 1973.**

Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.**

Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.**

Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.**

Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, June 1976.**

Developments in Aging: 1976—Part 1, Report No. 95-88, April 1977.**

Developments in Aging: 1976—Part 2, Report No. 95-88, April 1977.**

Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.**

Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.**

Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979.**

Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979.**

Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.**

Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980.**

Developments in Aging: 1980—Part 1, Report No. 97-62, May 1981.**

Developments in Aging: 1980—Part 2, Report No. 97-62, May 1981.**

Developments in Aging: 1981—Volume 1, Report No. 97-314, March 1982.**

Developments in Aging: 1981—Volume 2, Report No. 97-314, March 1982.***

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Developments in Aging: 1982—Volume 1, Report No. 98-13, February 1983.**

Developments in Aging: 1982—Volume 2, Report No. 98-13, February 1983.**

Developments in Aging: 1983—Volume 1, Report No. 98-360, February 1984—$13.*

Developments in Aging: 1983—Volume 2, Report No. 98-360, February 1984—$8.

Developments in Aging: 1984—Volume 1, Report No. 99-5, February 1985.—$9.

Developments in Aging: 1984—Volume 2, Report No. 99-5, February 1985—$8.

Developments in Aging: 1985—Volume 1, Report No. 99-242, February 1986.***

Developments in Aging: 1985—Volume 2—Appendixes, Report No. 99-242, February 1986.*

Developments in Aging: 1985—Volume 3—America in Transition: An Aging Society.*

1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.**

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.**

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[1] Working paper incorporated as an appendix to the hearing.

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[1] Working paper incorporated as an appendix to the hearing.

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Retirement Income of the Aging:**
- Part 1. Washington, D.C., July 12 and 13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
- Part 7. Hannibal, Mo., December 13, 1961.
- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
- Part 10. Fort Lauderdale, Fla., February 15, 1962.

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- Part 1. Washington, D.C., August 22 and 23, 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Problems of the Aging:**
- Part 1. Washington, D.C., August 23 and 24, 1961.
- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
- Part 4. Las Vegas, Nev., October 25, 1961.
- Part 5. Eugene, Oreg., November 8, 1961.
- Part 6. Pocatello, Idaho, November 13, 1961.
- Part 7. Boise, Idaho, November 15, 1961.
- Part 8. Spokane, Wash., November 17, 1961.
- Part 9. Honolulu, Hawaii, November 27, 1961.
- Part 10. Lihue, Hawaii, November 29, 1961.
- Part 11. Wailuku, Hawaii, November 30, 1961.
- Part 12. Hilo, Hawaii, December 1, 1961.
- Part 13. Kansas City, Mo., December 6, 1961.

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- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
- Part 4. Boston, Mass., December 1, 1961.
- Part 5. Minneapolis, Minn., December 4, 1961.
- Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People:**
- Part 1. Washington, D.C., October 22 and 23, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.

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Relocation of Elderly People—Continued
  Part 5. Los Angeles, Calif., December 5, 1962.
  Part 6. San Francisco, Calif., December 7, 1962.
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  Part 1. Washington, D.C., January 15, 1963.
  Part 2. Washington, D.C., January 16, 1963.
  Part 3. Washington, D.C., January 17, 1963.
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  Part 1. Washington, D.C., December 11, 1963.
  Part 2. Los Angeles, Calif., January 9, 1964.
  Part 3. San Francisco, Calif., January 11, 1964.
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  Part 1. Washington, D.C., December 19, 1963.
  Part 2. Los Angeles, Calif., January 10, 1964.
  Part 3. San Francisco, Calif., January 13, 1964.
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  Part 1. San Francisco, Calif., January 13, 1964.
  Part 2. Washington, D.C., March 9, 1964.
  Part 3. Washington, D.C., March 10, 1964.
  Part 4A. Washington, D.C., April 6, 1964 (morning).
  Part 4B. Washington, D.C., April 6, 1964 (afternoon).
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  Part 1. Washington, D.C., January 16, 1964.
  Part 2. Boston, Mass., January 20, 1964.
  Part 3. Providence, R.I., January 21, 1964.
  Part 4. Saginaw, Mich., March 2, 1964.
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  Part 1. Washington, D.C., April 27, 1964.
  Part 2. Washington, D.C., April 28, 1964.
  Part 3. Washington, D.C., April 29, 1964.
  Part 4A. Appendix.
  Part 4B. Appendix.
Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.**
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  Part 1. Washington, D.C., May 5, 1964.
  Part 2. Washington, D.C., May 6, 1964.
  Part 3. Washington, D.C., May 7, 1964.
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  Part 1. Washington, D.C., May 18, 1964.
  Part 2. Washington, D.C., May 19, 1964.
  Part 3. Washington, D.C., May 20, 1964.
Preneed Burial Service, Washington, D.C., May 19, 1964.**
Conditions and Problems in the Nation's Nursing Homes:**
  Part 1. Indianapolis, Ind., February 11, 1965.
  Part 2. Cleveland, Ohio, February 15, 1965.
  Part 3. Los Angeles, Calif., February 17, 1965.
  Part 4. Denver, Colo., February 23, 1965.

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  Part 6. Boston, Mass., August 9, 1965.
  Part 7. Portland, Maine, August 13, 1965.
Extending Private Pension Coverage:**
  Part 1. Washington, D.C., March 4, 1965.
  Part 2. Washington, D.C., March 5 and 10, 1965.
The War on Poverty As It Affects Older Americans:**
  Part 1. Washington, D.C., June 16 and 17, 1965.
  Part 2. Newark, N.J., July 10, 1965.
  Part 3. Washington, D.C., January 19 and 20, 1966.
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  Part 1. Washington, D.C., August 18 and 19, 1965.
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  Part 1. Washington, D.C., January 17 and 18, 1967.
  Part 2. Tampa, Fla., February 3, 1967.
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  Part 2. Ann Arbor, Mich., July 26, 1967.
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  Part 1. Washington, D.C., June 22 and 23, 1967.
  Part 2. New York, N.Y., October 19, 1967.
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Rent Supplement Assistance to the Elderly, Washington, D.C., July 11, 1967.**
Long-Range Program and Research Needs in Aging and Related Fields, Washington, D.C., December 5 and 6, 1967.**
Hearing Loss, Hearing Aids, and the Elderly, Washington, D.C., July 18 and 19, 1968.**
Usefulness of the Model Cities Program to the Elderly:**
  Part 1. Washington, D.C., July 23, 1968.
  Part 2. Seattle, Wash., October 14, 1968.
  Part 3. Ogden, Utah, October 24, 1968.
  Part 4. Syracuse, N.Y., December 9, 1968.
  Part 5. Atlanta, Ga., December 11, 1968.
  Part 6. Boston, Mass., July 11, 1969.
  Part 7. Washington, D.C., October 14 and 15, 1969.
Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968.**

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Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans: **
  Part 1. Los Angeles, Calif., December 17, 1968.
  Part 2. El Paso, Tex., December 18, 1968.
  Part 3. San Antonio, Tex., December 19, 1968.
  Part 4. Washington, D.C., January 14 and 15, 1969.
  Part 5. Washington, D.C., November 20 and 21, 1969.
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  Part 1. Washington, D.C., survey hearing, April 29 and 30, 1969.
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  Part 3. Washington, D.C., health aspects, July 17 and 18, 1969.
  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.
  Part 6. Cape May, N.J., retirement community, August 15, 1969.
  Part 7. Washington, D.C., international perspectives, August 25, 1969.
  Part 8. Washington, D.C., national organizations, October 29, 1969.
  Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.
  Part 10A. Washington, D.C., pension aspects, February 17, 1970.
  Part 10B. Washington, D.C., pension aspects, February 18, 1970.
  Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.
The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns, Washington, D.C., July 25, 1969.**
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  Part 1. Washington, D.C., July 30, 1969.
  Part 2. St. Petersburg, Fla., January 9, 1970.
  Part 3. Hartford, Conn., January 15, 1970.
  Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
  Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
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  Part 9. Washington, D.C. (Salmonella), August 19, 1970.
  Part 10. Washington, D.C. (Salmonella), December 14, 1970.
  Part 11. Washington, D.C., December 17, 1970.
  Part 12. Chicago, Ill., April 2, 1971.
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  Part 14. Washington, D.C., June 15, 1971.
  Part 15. Chicago, Ill., September 14, 1971.
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  Part 18. Washington, D.C., October 28, 1971.
  Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
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  Part 20. Washington, D.C., August 10, 1972.
  Part 21. Washington, D.C., October 10, 1973.
  Part 22. Washington, D.C., October 11, 1973.
  Part 23. New York, N.Y., January 21, 1975.
  Part 24. New York, N.Y., February 4, 1975.
  Part 25. Washington, D.C., February 19, 1975.
  Part 26. Washington, D.C., December 9, 1975.
  Part 27. New York, N.Y., March 19, 1976.
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  Part 1. Des Moines, Iowa, September 8, 1969.
  Part 2. Majestic-Freeburn, Ky., September 12, 1969.
  Part 3. Fleming, Ky., September 12, 1969.
  Part 4. New Albany, Ind., September 16, 1969.
  Part 5. Greenwood, Miss., October 9, 1969.
  Part 6. Little Rock, Ark., October 10, 1969.
  Part 7. Emmett, Idaho, February 24, 1970.
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  Part 9. Washington, D.C., May 26, 1970.
  Part 10. Washington, D.C., June 2, 1970.
  Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
  Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.
Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970.**
Sources of Community Support for Federal Programs Serving Older Americans:**
  Part 1. Ocean Grove, N.J., April, 18, 1970.
  Part 2. Washington, D.C., June 8 and 9, 1970.
Legal Problems Affecting Older Americans:**
  Part 1. St. Louis, Mo., August 11, 1970.
  Part 2. Boston, Mass., April 30, 1971.
Evaluation of Administration on Aging and Conduct of White House Conference on Aging:**
  Part 1. Washington, D.C., March 25, 1971.
  Part 2. Washington, D.C., March 29, 1971.
  Part 3. Washington, D.C., March 30, 1971.
  Part 4. Washington, D.C., March 31, 1971.
  Part 5. Washington, D.C., April 27, 1971.
  Part 6. Orlando, Fla., May 10, 1971.
  Part 7. Des Moines, Iowa, May 13, 1971.
  Part 8. Boise, Idaho, May 28, 1971.
  Part 9. Casper, Wyo., August 13, 1971.
  Part 10. Washington, D.C., February 3, 1972.
Cutbacks in Medicare and Medicaid Coverage:**
  Part 1. Los Angeles, Calif., May 10, 1971.
  Part 2. Woonsocket, R.I., June 14, 1971.
  Part 3. Providence, R.I., September 20, 1971.

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Unemployment Among Older Workers: **
- Part 1. South Bend, Ind., June 4, 1971.
- Part 2. Roanoke, Ala., August 10, 1971.
- Part 3. Miami, Fla., August 11, 1971.
- Part 4. Pocatello, Idaho, August 27, 1971.

Adequacy of Federal Response to Housing Needs of Older Americans:**
- Part 1. Washington, D.C., August 2, 1971.
- Part 2. Washington, D.C., August 3, 1971.
- Part 3. Washington, D.C., August 4, 1971.
- Part 4. Washington, D.C., October 28, 1971.
- Part 5. Washington, D.C., October 29, 1971.
- Part 6. Washington, D.C., July 31, 1972.
- Part 7. Washington, D.C., August 1, 1972.
- Part 8. Washington, D.C., August 2, 1972.
- Part 9. Boston, Mass., October 2, 1972.
- Part 10. Trenton, N.J., January 17, 1974.
- Part 11. Atlantic City, N.J., January 18, 1974.
- Part 12. East Orange, N.J., January 19, 1974.
- Part 13. Washington, D.C., October 7, 1975.
- Part 14. Washington, D.C., October 8, 1975.

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- Part 1. Washington, D.C., October 18, 1971.
- Part 2. Washington, D.C., October 19, 1971.
- Part 3. Washington, D.C., October 20, 1971.

Death With Dignity: An Inquiry Into Related Public Issues:**
- Part 1. Washington, D.C., August 7, 1972.
- Part 2. Washington, D.C., August 8, 1972.
- Part 3. Washington, D.C., August 9, 1972.

Future Directions in Social Security:**
- Part 1. Washington, D.C., January 15, 1973.
- Part 2. Washington, D.C., January 22, 1973.
- Part 3. Washington, D.C., January 23, 1973.
- Part 4. Washington, D.C., July 25, 1973.
- Part 5. Washington, D.C., July 26, 1973.
- Part 6. Twin Falls, Idaho, May 16, 1974.
- Part 7. Washington, D.C., July 15, 1974.
- Part 8. Washington, D.C., July 16, 1974.
- Part 9. Washington, D.C., March 18, 1975.
- Part 10. Washington, D.C., March 19, 1975.
- Part 11. Washington, D.C., March 20, 1975.
- Part 12. Washington, D.C., May 1, 1975.
- Part 13. San Francisco, Calif., May 15, 1975.
- Part 14. Los Angeles, Calif., May 16, 1975.
- Part 15. Des Moines, Iowa, May 19, 1975.
- Part 16. Newark, N.J., June 30, 1975.
- Part 17. Toms River, N.J., September 8, 1975.
- Part 18. Washington, D.C., October 22, 1975.

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Future Directions in Social Security—Continued
  Part 19. Washington, D.C., October 23, 1975.
  Part 20. Portland, Oreg., November 24, 1975.
  Part 21. Portland, Oreg., November 25, 1975.
  Part 22. Nashville, Tenn., December 6, 1975.
  Part 23. Boston, Mass., December 19, 1975.
  Part 24. Providence, R.I., January 26, 1976.
  Part 25. Memphis, Tenn., February 13, 1976.
Fire Safety in Highrise Buildings for the Elderly:**
  Part 1. Washington, D.C., February 27, 1973.
  Part 2. Washington, D.C., February 28, 1973.
Barriers to Health Care for Older Americans:**
  Part 1. Washington, D.C., March 5, 1973.
  Part 2. Washington, D.C., March 6, 1973.
  Part 3. Livermore Falls, Maine, April 23, 1973.
  Part 4. Springfield, Ill., May 16, 1973.
  Part 5. Washington, D.C., July 11, 1973.
  Part 6. Washington, D.C., July 12, 1973.
  Part 7. Coeur d'Alene, Idaho, August 4, 1973.
  Part 8. Washington, D.C., March 12, 1974.
  Part 9. Washington, D.C., March 13, 1974.
  Part 10. Price, Utah, April 20, 1974.
  Part 11. Albuquerque, N. Mex., May 25, 1974.
  Part 12. Santa Fe, N. Mex., May 25, 1974.
  Part 13. Washington, D.C., June 25, 1974.
  Part 14. Washington, D.C., June 26, 1974.
  Part 15. Washington, D.C., July 9, 1974.
  Part 16. Washington, D.C., July 17, 1974.
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  Part 1. Washington, D.C., June 19, 1973.
  Part 2. Washington, D.C., June 21, 1973.
  Part 3. Washington, D.C., March 7, 1975.
Hearing Aids and the Older American:**
  Part 1. Washington, D.C., September 10, 1973.
  Part 2. Washington, D.C., September 11, 1973.
Transportation and the Elderly: Problems and Progress:**
  Part 1. Washington, D.C., February 25, 1974.
  Part 2. Washington, D.C., February 27, 1974.
  Part 3. Washington, D.C., February 28, 1974.
  Part 4. Washington, D.C., April 9, 1974.
  Part 5. Washington, D.C., July 29, 1975.
  Part 6. Washington, D.C., July 12, 1977.
Improving Legal Representation for Older Americans:**
  Part 1. Los Angeles, Calif., June 14, 1974.
  Part 2. Boston, Mass., August 30, 1976.
  Part 3. Washington, D.C., September 28, 1976.
  Part 4. Washington, D.C., September 29, 1976.
Establishing a National Institute on Aging, Washington, D.C., August 1, 1974.**
The Impact of Rising Energy Costs on Older Americans:**
  Part 1. Washington, D.C., September 24, 1974.

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The Impact of Rising Energy Costs—Continued
  Part 2. Washington, D.C., September 25, 1974.
  Part 3. Washington, D.C., November 7, 1975.
  Part 4. Washington, D.C., April 5, 1977.
  Part 5. Washington, D.C., April 7, 1977.
  Part 6. Washington, D.C., June 28, 1977.
  Part 7. Missoula, Mont., February 14, 1979.
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  Part 1. Washington, D.C., June 6, 1975.
  Part 2. Washington, D.C., June 26, 1975.
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  Part 1. Washington, D.C., September 26, 1975.
  Part 2. Washington, D.C., November 13, 1975.
  Part 3. Washington, D.C., December 5, 1975.
  Part 4. Washington, D.C., February 16, 1976.
  Part 5. Washington, D.C., August 30, 1976.
  Part 6. Washington, D.C., August 31, 1976.
  Part 7. Washington, D.C., November 17, 1976.
  Part 8. Washington, D.C., March 8, 1977.
  Part 9. Washington, D.C., March 9, 1977.
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  Part 1. Winterset, Iowa, August 16, 1976.
  Part 2. Ottumwa, Iowa, August 16, 1976.
  Part 3. Gretna, Nebr., August 17, 1976.
  Part 4. Ida Grove, Iowa, August 17, 1976.
  Part 5. Sioux Falls, S. Dak., August 18, 1976.
  Part 6. Rockford, Iowa, August 18, 1976.
  Part 7. Denver, Colo., March 23, 1977.
  Part 8. Flagstaff, Ariz., November 5, 1977.
  Part 9. Tucson, Ariz., November 7, 1977.
  Part 10. Terre Haute, Ind., November 11, 1977.
  Part 11. Phoenix, Ariz., November 12, 1977.
  Part 12. Roswell, N. Mex., November 18, 1977.
  Part 13. Taos, N. Mex., November 19, 1977.
  Part 14. Albuquerque, N. Mex., November 21, 1977.
  Part 15. Pensacola, Fla., November 21, 1977.
  Part 16. Gainesville, Fla., November 22, 1977.
  Part 17. Champaign, Ill., December 13, 1977.

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  Part 1. Washington, D.C., April 18, 1977.
  Part 2. Washington, D.C., April 19, 1977.
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  Part 1. Washington, D.C., May 16, 1977.
  Part 2. Washington, D.C., May 17, 1977.
  Part 3. Washington, D.C., June 15, 1977.
  Part 4. Cleveland, Ohio, July 6, 1977.
  Part 5. Washington, D.C., September 21, 1977.
  Part 6. Holyoke, Mass., October 12, 1977.
  Part 7. Tallahassee, Fla., November 23, 1977.
  Part 8. Washington, D.C., April 17, 1978.
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  Part 1. Washington, D.C., May 16, 1978.
  Part 2. Washington, D.C., June 29, 1978.
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  Part 1. Washington, D.C., July 17, 1978.
  Part 2. Washington, D.C., July 18, 1978.
  Part 3. Washington, D.C., July 19, 1978.
  Part 4. Washington, D.C., September 8, 1978.
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The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives," Chicago, Ill., August 30, 1978.**
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  Part 1. Hallandale, Fla., November 28, 1978.
  Part 2. West Palm Beach, Fla., November 29, 1978.
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  Part 1. Washington, D.C., December 1, 1978.
  Part 2. Oakland, Calif., December 4, 1978.
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Abuse of the Medicare Home Health Program, Miami, Fla., August 28, 1979.**

Occupational Health Hazards of Older Workers in New Mexico, Grants, N. Mex., August 30, 1979.**

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Part 1. Akron, Ohio, August 30, 1979.
Part 2. Washington, D.C., September 13, 1979.
Part 3. Pennsauken, N.J., May 23, 1980.
Part 4. Washington, D.C., July 25, 1980.

Regulations To Implement the Comprehensive Older Americans Act Amendments of 1978:**

Part 1. Washington, D.C., October 18, 1979.
Part 2. Washington, D.C., March 24, 1980.

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Part 1. Little Rock, Ark., April 4, 1980.
Part 2. Washington, D.C., May 22, 1980.

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Part 1. Washington, D.C., April 24, 1980.
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Part 3. Orlando, Fla., July 9, 1980.

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Part 2. St. Petersburg, Fla., October 28, 1980.

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Social Security: What Changes Are Necessary?:**

Part 1. Washington, D.C., November 21, 1980.
Part 2. Washington, D.C., December 2, 1980.

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Social Security—Continued
    Part 3. Washington, D.C., December 3, 1980.
    Part 4. Washington, D.C., December 4, 1980.
Home Health Care: Future Policy (joint hearing with Senate Committee on Labor and Human Resources), Princeton, N.J., November 23, 1980.**
Impact of Federal Estate Tax Policies on Rural Women, Washington, D.C., February 4, 1981.**
Impact of Federal Budget Proposals on Older Americans:**
    Part 1. Washington, D.C., March 20, 1981.
    Part 2. Washington, D.C., March 27, 1981.
    Part 3. Philadelphia, Pa., April 10, 1981.
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    Part 1 (Short-Term Financing Issues). Washington, D.C., June 16, 1981.
    Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
    Part 3 (Cost-of-Living Adjustments). Washington, D.C., June 24, 1981.
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Long-Term Health Care for the Elderly, Newark, N.J., July 26, 1982.**

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Health Care for Older Americans: Insuring Against Catastrophic Loss, Serial No. 99-26.***
  Part 1. Fort Smith, AR, August 27, 1986.
  Part 2. Little Rock, AR, August 28, 1986.
Continuum of Health Care for Indian Elders, Santa Fe, NM, September 3, 1986, Serial No. 99-27.***

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